

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22001

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

YOLANDA NORRINE REID

2. Date of Death

Month Day Year  
JUNE 23, 2000

3. Time of Death

7:47 PM

4a. Facility Name (If not Institution, give street and number)

DOCTORS COMMUNITY HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

578-50-5106

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 14 1926

9. Birthplace (State or Foreign Country)

Wash., DC

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince George's

10c. City, Town or Location

Landover

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5648 Whitfield Chapel Road

10f. Zip Code

20706

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Clerk

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

John Reid

18. Mother's Name (First, Middle, Maiden Surname)

Marion Walter

19a. Informant's Name/Relationship (Type, Print)

Cassandra Thompson / Goddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5648 Whitfield Chapel Rd. #203 Landover, Md 20706

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pleasant Grove Cemetery

Date

6-29-00

20c. Location - City or Town, State

McLean, VA

21. Signature of Funeral Service Licensee

Larry Cuffee

22. Name and Address of Facility

Capitol Mortuary, Inc.

1425 Maryland Ave., NE Wash., DC 20002

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

METASTATIC LUNG CANCER

Approximate Interval Between Onset and Death

3 MONTH

Due to (or as a consequence of):

CHRONIC OBSTRUCTIVE LUNG DISEASE

10 YRS

Due to (or as a consequence of):

PNEUMONIA

&lt; 1 WEEK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Ruyang

29c. License number

D0015558

29d. Date signed (Month, Day, Year)

06/26/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

S.C. ARYANGAT, MD

3308 PERRY ST, MT. RAINIER, MD 20712

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

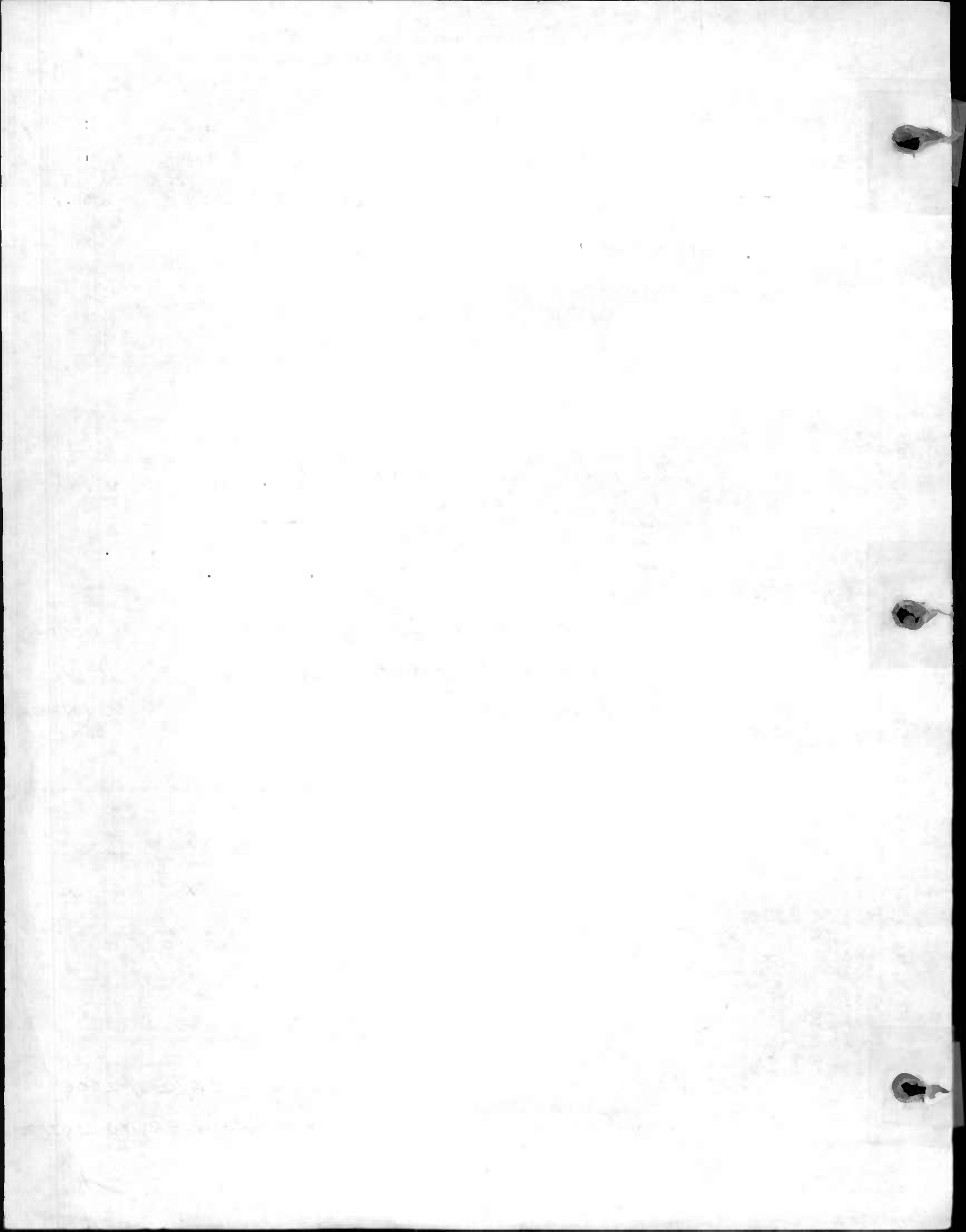
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 22002

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEO DAVID RHODE

2. Date of Death

Month Day Year  
JUNE 18, 2000

3. Time of Death

10:30 am

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

112-10-0228

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 13, 1915

9. Birthplace (State or Foreign)

MASS.

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6111 MONTROSE RD

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

BAKERY CLERK

16b. Kind of Business/Industry

BAKERY

17. Father's Name (First, Middle, Last)

MORRIS RHODE

18. Mother's Name (First, Middle, Maiden Surname)

LENA CHAZEN

19a. Informant's Name/Relationship (Type, Print)

ROSE D. RHODE WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6111 MONTROSE RD. ROCKVILLE MD. 20852

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MT. COMFORT CREMATORY

Date

JUNE 21, 2000

20c. Location - City or Town, State

ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee

Donald C. Stottmeyer

22. Name and Address of Facility

DANZANSKY-MEMORIAL CHAPELS INC.  
1170 ROCKVILLE PIKE ROCKVILLE, MD. 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction

Due to (or as a consequence of):

b. coronary artery disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gay B. Wilks, M.D.

29c. License number

00055258

29d. Date signed (Month, Day, Year)

June 18, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GARY B. WILKS, MD Hebrew Home 6121 Montrose Road Rockville Maryland 20852

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

Barbara B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22003

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>PHILIP MAURICE RISIK</b>				2. Date of Death Month Day Year <b>JUNE 27 2000</b>				3. Time of Death <b>8:50 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BETHESDA</b>				4c. County of Death <b>MONTGOMERY</b>	
5. Social Security Number <b>084-03-5948</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN. 8, 1914</b>		9. Birthplace (State or Foreign Country) <b>NEW YORK</b>	
Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>POTOMAC</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>10224 WINDSOR VIEW DR.</b>				10f. Zip Code <b>20854</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>JUDGE</b>			16b. Kind of Business/Industry <b>LAW</b>		
17. Father's Name (First, Middle, Last) <b>ISIDORE RISIK</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>CELIA MERKEN</b>				
19a. Informant's Name/Relationship (Type, Print) <b>ELIZABETH I. SALTER/ DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9412 EAGLE RIDGE DR., BETHESDA, MD 20817</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>NATIONAL CREMATORY</b>			Date <b>JUNE 30, 2000</b>		20c. Location - City or Town, State <b>FALLS CHURCH, VA</b>	
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS</b> e. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number <b>97-01873(NC)</b>		29d. Date signed (Month, Day, Year) <b>06/28/00</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JOSEPH J. SPOSATO, LT, MC, USNR</b>				<b>NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600</b>					
31. Date filed (Month, Day, Year) <b>JUN 30 2000</b>		32. Registrar's Signature 							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22004

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ANNA LEA ROCKOWITZ

2. Date of Death

JUN 22 2000

3. Time of Death

4:49 AM

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

240-12-8630

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 15, 1920

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Virginia

10b. County

Fairfax

10c. City, Town or Location

Falls Church

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7218 Timber Lane

10f. Zip Code

22046

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12) College (1-4 or 5+)

4

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Administrative

16b. Kind of Business/Industry

Federal Government

17. Father's Name (First, Middle, Last)

Jacob Samuel Brown

18. Mother's Name (First, Middle, Maiden Surname)

Ida Arner

19a. Informant's Name/Relationship (Type, Print)

Mr. Stuart Rockowitz/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7218 Timber Lane, Falls Church, Virginia 22046

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)  
King David Mem. Gardens

Date

June 25,  
2000

20c. Location - City or Town, State

Falls Church, Virginia

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Pearson Funeral Home  
472 N. Washington Street, Falls Church, VA23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

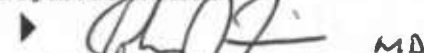
M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

153491 (MA)

29d. Date signed (Month, Day, Year)

22 JUN 00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

NATIONAL NAVAL MEDICAL CENTER

J.J. FROIO, LT, MC, USN

BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1954

1954 - 1955

1954 - 1955

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1954 - 1955



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State of Maryland / Department of Health and Mental Hygiene

00 22005

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ADOLPH ROSENZWEIG

2. Date of Death

JUNE 24, 2000

3. Time of Death

11:55 AM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

057-01-7253

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 19, 1911

9. Birthplace (State or Foreign Country)

NY

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

6121 MONTROSE ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SALESMAN

16b. Kind of Business/Industry

FURNITURE

17. Father's Name (First, Middle, Last)

MICHAEL ROSENZWEIG

18. Mother's Name (First, Middle, Maiden Surname)

YOLAN ROSENZWEIG

19a. Informant's Name/Relationship (Type, Print)

BEN ROSENZWEIG/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7502 OYSEY BAY WAY, MONTGOMERY VILLAGE, MD 20886

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS 6.26.2000 OLNEY, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.

1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE CONGESTIVE HEART FAILURE HOURS

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE YEARS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D05885

29d. Date signed (Month, Day, Year)

06/26/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

STEVEN LIPSON 6121 MONTROSE ROAD, ROCKVILLE

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

State  
Registrar

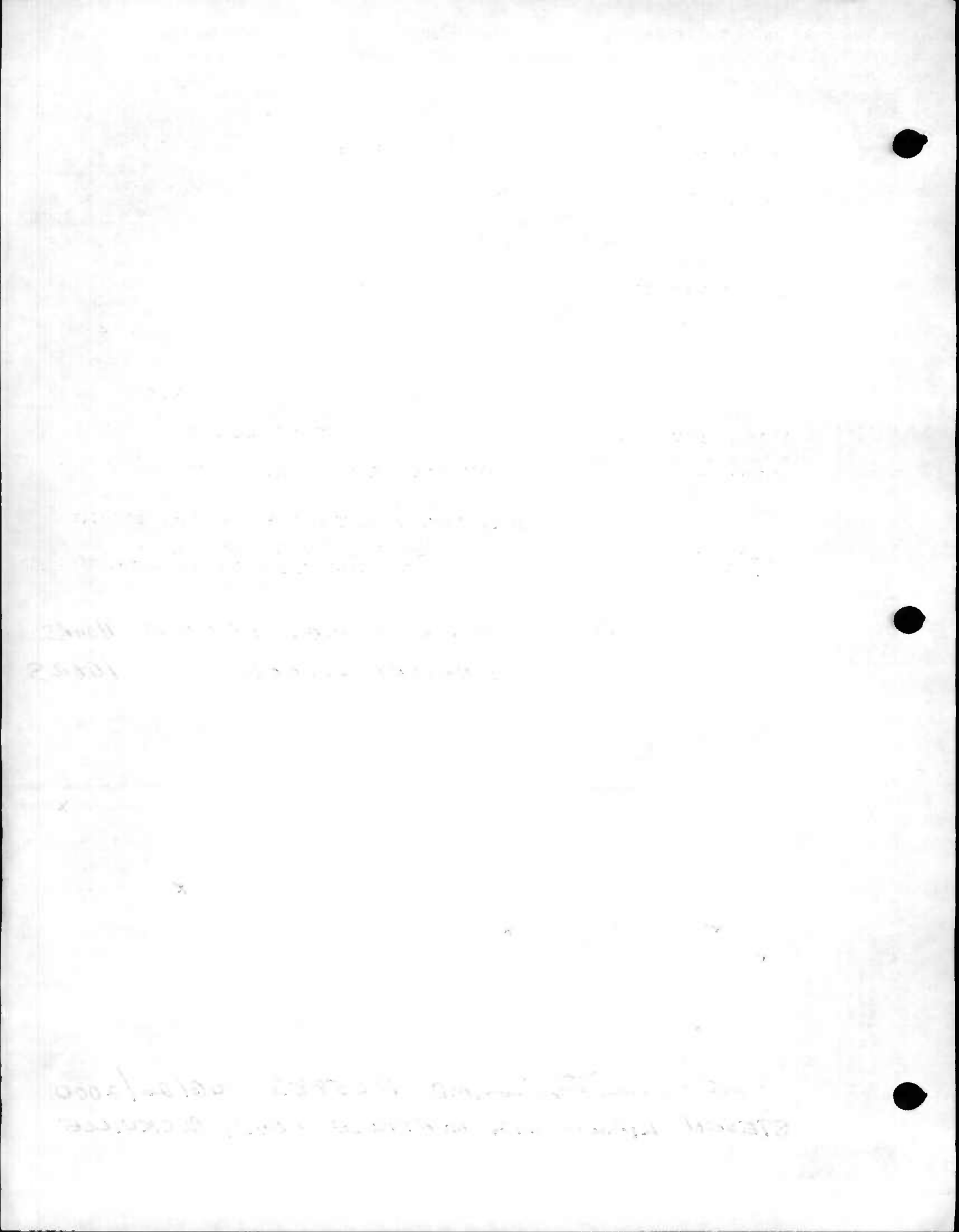
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22006

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Lee Royal, Sr.</b>				2. Date of Death Month <b>June</b> Day <b>22</b> Year <b>2000</b>		3. Time of Death <b>3:00 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>
Funeral Director	5. Social Security Number <b>577-26-5328</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>April 16, 1925</b>	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>
	Usual Residence of Decedent						
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Germantown</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>21 Sunnyview Court</b>				10f. Zip Code <b>20876</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942/1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Field Service Manager</b>		16b. Kind of Business/Industry <b>Business Machines</b>	
17. Father's Name (First, Middle, Last) <b>Stephen Robert Royal</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Ellis</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mary A. Royal/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21 Sunnyview Court, Germantown, Maryland 20876</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Date <b>6/23/00</b>		20d. Location - City or Town, State <b>Alexandria, Virginia</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD. 20877</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>Pneumonia</b> Due to (or as a consequence of):  b. <b>Radiation Pneumonitis</b> Due to (or as a consequence of):  c. <b>Lung Cancer</b> Due to (or as a consequence of):  d.							Approximate Interval Between Onset and Death  <b>3 weeks</b>  <b>2 months</b>  <b>10 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier  <b>David A. Holden MD</b>				29c. License number <b>D 47791</b>		29d. Date signed (Month, Day, Year) <b>June 22, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David A. Holden, M.D. 809 Veirs Mill Road, Rockville, Maryland 20851</b>							
31. Date filed (Month, Day, Year) <b>JUN 27 2000</b>		32. Registrar's Signature  <b>B. Sparks</b>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22007

Amend #28a,c,d,e,6/28/2000,BMW, Montg.Co.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARTIN RUEBENS</b>				2. Date of Death Month <b>06</b> Day <b>21</b> Year <b>2000</b>			3. Time of Death <b>12:55 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>HOLYCROSS HOSPITAL</b>				4b. City, Town, or Location of Death <b>SILVERSPRING</b>			4c. County of Death <b>MONTGOMERY</b>			
Funeral Director	5. Social Security Number <b>180-16-5554</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov 16, 1924</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		
	Usual Residence of Decedent				10c. City, Town or Location		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
10a. State <b>Virginia</b>		10b. County <b>Stafford</b>		10e. Street and Number <b>2030 Admiral Drive</b>				10f. Zip Code <b>22554</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942-1966</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Director of Health Care</b>				16b. Kind of Business/Industry <b>U.S. Coast Guard</b>			
17. Fether's Name (First, Middle, Last) <b>Morris Ruebens</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Gertrude Frankel</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Mark A. Ruebens (son)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3020 Shanandale Drive, Silver Spring, MD 20904</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Cemetery 2000</b>			Date <b>6/29</b>		20c. Location - City or Town, State <b>Arlington, VA</b>			
21. Signature of Funeral Service Licensee <b>Robert E. Ramsey</b>					22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>RESPIRATORY FAILURE</b> Due to (or as a consequence of):  b. <b>MALIGNANT PLEURAL EFFUSION</b> Due to (or as a consequence of):  c. <b>END STAGE NON HODGKINS LYMPHOMA</b> Due to (or as a consequence of):  d. <b>CONGESTIVE HEART FAILURE</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year) <b>NA</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>NA</b>		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>NA</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <b>V. Sherkle Anthony M.D.</b>				29c. License number <b>00051158</b>			29d. Date signed (Month, Day, Year) <b>06/22/2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>VAN T. ANTHONY M.D. 2401 RESEARCH BLVD #102 ROCKVILLE MD 20850</b>											
31. Date filed (Month, Day, Year) <b>JUN 28 2000</b>			32. Registrar's Signature <b>Benjamin B. Sparks</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22008

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Stewart Randall Stinchcomb, Sr.</b>				2. Date of Death Month Day Year <b>June 17 2000</b>		3. Time of Death <b>9:53 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Northwest Hospital Center</b>				4b. City, Town, or Location of Death <b>Randallstown</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>219-30-1448</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66 Yrs.</b>	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug 19 1933</b>	
Usual Residence of Decedent				9. Birthplace (State or Foreign Country) <b>Maryland</b>			
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Randallstown</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>3705 Lanamer Road</b>				10f. Zip Code <b>21133</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sheaffer Eaton Inc.</b>		16b. Kind of Business/Industry <b>Sales</b>	
17. Father's Name (First, Middle, Last) <b>Maurice Stinchcomb</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Stewart</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Sandra Lee Stinchcomb Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3705 Lanamer Road Randallstown, MD 21133</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lake View Memorial Park</b>		Date <b>6/22/2000</b>		20c. Location - City or Town, State <b>Sykesville, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784</b>			
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Atherosclerotic Cardiovascular Disease</b>  Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Melitus</b> <b>Morbid Obesity</b>							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>D47587</b>		29d. Date signed (Month, Day, Year) <b>JUNE 17, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ROBERT FINE, MD 5401 OLD CANT ROAD, RANDALLSTOWN, MD 21133</b>							
31. Date filed (Month, Day, Year) <b>JUN 26 2000</b>		32. Registrar's Signature 					

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22009

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Cecil Snyder

2. Date of Death

June 22 2000

3. Time of Death

0642

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Carroll County Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

218-24-9124

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept 27 1930

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Manchester

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2909 Park Avenue

10f. Zip Code

21102

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Snyder Body Inc.

17. Father's Name (First, Middle, Last)

George C. Snyder

18. Mother's Name (First, Middle, Maiden Surname)

Maxine Wheeler

19a. Informant's Name/Relationship (Type, Print)

Dolores Snyder/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2909 Park Ave Manchester, MD 21102

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Greenmount Cem

Date

6/23

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Pritts Funeral Home and Chapel  
412 Washington Rd Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MASSIVE INTRACEREBRAL HEMORRAGE

Due to (or as a consequence of):

b. HYPERTENSION

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D51596

29d. Date signed (Month, Day, Year)

June 22 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

K. AMBALAVANAR, 200 MEMORIAL AVE, WESTMINSTER, MD 21157

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22010

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JEREMIAH WILLIAM SNYDER</b>				2. Date of Death Month Day Year <b>JUNE 14 2000</b>		3. Time of Death <b>7:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick County</b>	
Funeral Director	5. Social Security Number <b>189-09-6826</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>May 30, 1910</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick County</b>		10c. City, Town or Location <b>Emmitsburg</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>16405 Tom's Creek Church Road</b>		10f. Zip Code <b>21727</b>		10g. Citizen of What Country? <b>United States</b>			
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>factory worker</b>		16b. Kind of Business/Industry <b>rubber manufacture</b>			
	17. Father's Name (First, Middle, Last) <b>Clarence Orville Snyder</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ellie Elizabeth Houck</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Lena A. Snyder / wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16405 Tom's Creek Church Road Emmitsburg, MD 21727</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Keyville Union Cemetery</b>		Data <b>June 17 2000</b>		20c. Location - City or Town, State <b>Keymar, Maryland</b>	
	21. Signature of Funeral Service Licensee <b>Alan C. ...</b> MO1072		22. Name and Address of Facility <b>Skiles Funeral Home 136 East Baltimore Street Taneytown, MD 21787</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Left Pneumonia</b> Due to (or as a consequence of):							
	23b. Approximate Interval Between Onset and Death <b>days</b>							
	23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Congestive Heart Failure</b> <b>Renal Insufficiency</b> <b>COPD</b>							
23d. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Allen J. G...</b>				29c. License number <b>D26516</b>		29d. Date signed (Month, Day, Year) <b>JUNE 14 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Allen J. G... 1475 TANEY AVE (FRED MD) 21702</b>								
31. Date filed (Month, Day, Year) <b>JUN 16 2000</b>		32. Registrar's Signature <b>...</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22011

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANCES BARRICK STONESIFER</b>				2. Date of Death Month Day Year <b>June 15, 2000</b>				3. Time of Death <b>9:26am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Glade Valley Nursing &amp; Rehab. Ctr</b>				4b. City, Town, or Location of Death <b>Walkersville</b>				4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>217-62-7436</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar. 31, 1916</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Carroll</b>		10c. City, Town or Location <b>Keymar</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>2017 Reifsnider Rd.</b>				10f. Zip Code <b>21757</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>Harry Barrick</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Carrie Hinea</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>James H. Stonesifer/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13901 Motters Station Rd., Rocky Ridge, MD 21778</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Grace UCC Cemetery</b>		Date <b>06/20</b>		20c. Location - City or Town, State <b>Taneytown, MD</b>			
	21. Signature of Funeral Service Licensee <b>John M. Shilow</b>				22. Name and Address of Facility <b>Skiles Funeral Home</b> <b>136 E. Baltimore St. Taneytown, MD 21787</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Several Decubitus Ulcers</b> Due to (or as a consequence of): b. <b>Radiation</b> Due to (or as a consequence of): c. <b>Pelvic Irradiation for</b> Due to (or as a consequence of): d. <b>Ovarian Carcinoma (cured)</b>									
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b> <b>Dietetics</b>										
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Allen J. Gilson</b>		29c. License number <b>D26516</b>		29d. Date signed (Month, Day, Year) <b>JUNE 15 2000</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Allen J. Gilson MD 1475 TANEY AVE FRED MD 21702</b>									
	31. Date filed (Month, Day, Year) <b>JUN 16 2000</b>		32. Registrar's Signature <b>[Signature]</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

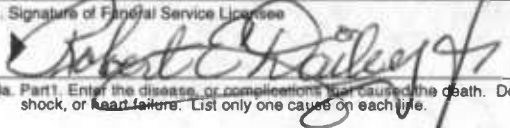
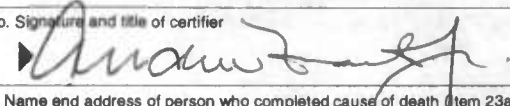

State of Maryland / Department of Health and Mental Hygiene

00 22012

~~Amended item#~~

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARVIN HERBERT SEDON</b>				2. Date of Death Month Day Year <b>June 12, 2000</b>		3. Time of Death <b>0437</b>	
	4a. Facility Name (If not institution, give street and number) <b>Homewood at Crumland Farms</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>370-03-7986</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 5, 1918</b>	
	9. Birthplace (State or Foreign Country) <b>Michigan</b>		10a. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>7407 Willow Road</b>		10f. Zip Code <b>21702</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Civil Engineer</b>		16b. Kind of Business/Industry <b>U.S. Government</b>		17. Father's Name (First, Middle, Last) <b>Sam Sedon</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Nora Sapperstein</b>		19a. Informant's Name/Relationship (Type, Print) <b>Douglas N. Sedon</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2815 Fry Road, Jefferson, Maryland 21755</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington Nat. Cemetery</b>		20c. Date <b>6/30/00</b>		20d. Location - City or Town, State <b>Arlington, VA</b>		21. Signature of Funeral Service Licensee 		
22. Name and Address of Facility <b>ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701</b>		23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>ASCVD</b> Due to (or as a consequence of):  f. <b>Dementia</b> Due to (or as a consequence of):  g. <b>Right Hip Fracture</b> Due to (or as a consequence of):  h. Due to (or as a consequence of):		Approximate Interval Between Onset and Death <b>Years</b> <b>Years</b> <b>2 months</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>April 22, 2000</b>		28b. Time of Injury <b>12:00 PM</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred <b>Fell</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Nursing Home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>5800 Genesis Lane Frederick.</b>		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		
29b. Signature and title of certifier 		29c. License number <b>D35164</b>		29d. Date signed (Month, Day, Year) <b>June 13, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Andrew Zarick, MD 1080 West Patrick Street, Frederick, Maryland 21701</b>		
31. Date filed (Month, Day, Year) <b>JUN 14 2000</b>		32. Registrar's Signature 		33. State Registrar <b>State Registrar</b>		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 22013

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jack Bane Smith</b>				2. Date of Death Month Day Year <b>June 17, 2000</b>		3. Time of Death <b>11:50 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Frederick Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Frederick</b>		4c. County of Death <b>Frederick</b>	
Funeral Director	5. Social Security Number <b>227-10-0242</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 11, 1919</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Clarksburg</b>	
Usual Residence of Decedent		10e. Street and Number <b>22334 New Cut Road</b>		10f. Zip Code <b>20871</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Foreman</b>		16b. Kind of Business/Industry <b>Carpentry</b>				
17. Father's Name (First, Middle, Last) <b>Roby Y. Smith</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bertha E. Wilson</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Lovell S. Smith / Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>22334 New Cut Road, Clarksburg, Maryland 20871</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenhills Memory Gardens</b>		20c. Date <b>6/22</b>		20d. Location - City or Town, State <b>Claypool Hill, Virginia</b>		
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland 20872</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>SEPTICEMIA - STAPH. AUREUS</b> Due to (or as a consequence of): <b>INTERNAL</b>		b. <b>CATHETER INFECTION - JUGULAR</b> Due to (or as a consequence of):		c. <b>SEPTIC ARTHRITIS - KNEE</b> Due to (or as a consequence of):		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>END STAGE RENAL FAILURE/HEMODIALYSIS</b> <b>DEMENTIA</b> <b>CARDIOMYOPATHY</b> <b>HTX of SMOKING</b> <b>A. FIBRILLATION</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D47556</b>		29d. Date signed (Month, Day, Year) <b>6-17-00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>WILLIAM H. JOHNSON, 172 THOMAS JOHNSON DRIVE, FREDERICK, MD 21702</b>								
31. Date filed (Month, Day, Year) <b>JUN 21 2000</b>		32. Registrar's Signature 						

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 22014

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) RICHARD C. SHANKLE				2. Date of Death Month Day Year June 19, 2000		3. Time of Death 5:00 A.M.	
	4a. Facility Name (If not institution, give street and number) 9314 Links Road				4b. City, Town, or Location of Death Walkersville		4c. County of Death Frederick	
Funeral Director	5. Social Security Number 220-18-1706		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 72 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 27, 1927	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County Frederick		10c. City, Town or Location Walkersville	
Usual Residence of Decedent								
10a. State Maryland			10b. County Frederick			10c. City, Town or Location Walkersville		
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			10e. Street and Number 9314 Links Road			10f. Zip Code 21793		
10g. Citizen of What Country? United States			11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: WWII		
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Staff Sergeant			16b. Kind of Business/Industry U.S. Army			17. Father's Name (First, Middle, Last) Clarence Shankle		
18. Mother's Name (First, Middle, Maiden Surname) Daisy Holt			19a. Informant's Name/Relationship (Type, Print) Sarah I. Shankle / Wife			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9314 Links Road, Walkersville, Maryland 21793		
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment			20b. Place of Disposition (Name of cemetery, crematory or other place) Resthaven Memorial Park			20c. Location - City or Town, State June 22 2000 Frederick, Maryland		
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Maryland 21702					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYPOXIA Due to (or as a consequence of): CHRONIC OBSTRUCTIVE PULMONARY DISEASE yrs. Due to (or as a consequence of): Pulmonary hypertension yrs. Due to (or as a consequence of): Smoking yrs.								
23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)			28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 			29c. License number 1D46861			29d. Date signed (Month, Day, Year) 6/19/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAEZ A. HUSSAIN M.D. 195 T.J Dr Frederick MD 21702								
31. Date filed (Month, Day, Year) JUN 19 2000			32. Registrar's Signature 					

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22015

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Victor Shaff, Jr.

2. Date of Death  
Month Day Year

June 19, 2000

3. Time of Death

12:15 AM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

College View Nursing Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

214-10-1113

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

May 31, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6050 Elmer Derr Road

10f. Zip Code

21703

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1944-  
If Yes, Give Year or Dates: 194613. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Saw Mill Operator

16b. Kind of Business/Industry

Building/Lumber

17. Father's Name (First, Middle, Last)

James Victor Shaff Sr

18. Mother's Name (First, Middle, Maiden Surname)

Phoebe Stockman

19a. Informant's Name/Relationship (Type, Print)

Mrs Ruby P. Shaff/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6050 Elmer Derr Road, Frederick, Maryland 21703

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

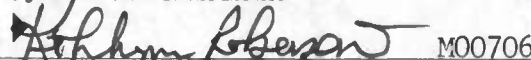
Mt Olivet Cemetery Jun 22, 2000

Data

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

 M00706

22. Name and Address of Facility

Keeney &amp; Basford Funeral Home

106 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 DAYS

b. EMPHYSEMA

Due to (or as a consequence of):

10 YRS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 MD

29c. License number

DA7611

29d. Date signed (Month, Day, Year)

6-19-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neil Warner MD 1475 TANEY AVE #204 FREDERICK MD 21702

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 20 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 505-555-5555.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

00 22016

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WALBORG

SEDLACEK

2. Date of Death

Month  
JUNEDay  
24Year  
2000

3. Time of Death

9:48 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

323-09-1090

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
OCT. 1, 1910

9. Birthplace (State or Foreign Country)

ILLINOIS

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

10201 GROSVENOR PL. #725

10f. Zip Code

20852

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

WILLIAM

JENSEN

18. Mother's Name (First, Middle, Maiden Surname)

MARIE

OSTERGARRD

19a. Informant's Name/Relationship (Type, Print)

EDWARD JOSEPH SEDLACEK/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

6/26/00

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W. W. Chambers M00091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 MONTHS

b. CORONARY HEART DISEASE

Due to (or as a consequence of):

YRS.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE, TEMPORAL ARTERITIS,

HYPERTENSION, CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residencia 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Martin C. Shargel, M.D.

29c. License number

D08944

29d. Date signed (Month, Day, Year)

JUNE 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARTIN C. SHARGEL, M.D. 3720 FARRAGUT AVE., KENSINGTON, MD. 20895

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

Beverly G. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

4





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22017

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Irene Sklias				2. Date of Death Month Day Year June 23 2000				3. Time of Death 9:20 PM		
	4a. Facility Name (If not institution, give street and number) Montgomery General Hospital				4b. City, Town, or Location of Death Olney				4c. County of Death Montgomery		
Funeral Director	5. Social Security Number 094-32-2649		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) Jan. 9, 1942		9. Birthplace (State or Foreign Country) Greece		
	Usual Residence of Decedent										
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 15329 Durant Street				10f. Zip Code 20905		10g. Citizen of What Country? USA					
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
17. Father's Name (First, Middle, Last) Spiros Sakellis				18. Mother's Name (First, Middle, Maiden Surname) Anna Hajimihalis							
19a. Informant's Name/Relationship (Type, Print) Nickolas Sklias / Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15329 Durant Street, Silver Spring, Maryland 20905							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Union Cemetery		Date 06/27/00		20c. Location - City or Town, State Burtonsville, Maryland			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ACUTE LYMPHOCTIC LEUKEMIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 4 years	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
								24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> VER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier 				29c. License number D 332 24				29d. Date signed (Month, Day, Year) JUNE 24, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. TREHAN 50W EDMONSTON DR #303 ROCKVILLE 20852											
31. Date filed (Month, Day, Year) JUN 27 2000				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10





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State of Maryland / Department of Health and Mental Hygiene

00 22018

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patricia Lee Terry</b>						2. Date of Death Month Day Year <b>June 22, 2000</b>		3. Time of Death <b>12:30 PM</b>													
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland</b>						4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>None</b>													
Funeral Director	5. Social Security Number <b>244-60-1398</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>61</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 26, 1938</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>													
	Usual Residence of Decedent																					
10a. State <b>MD.</b>		10b. County <b>None</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No														
10e. Street and Number <b>1807 West Lafayette Ave.</b>				10f. Zip Code <b>21217</b>				10g. Citizen of What Country? <b>USA</b>														
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Pharmacy Assistant</b>				16b. Kind of Business/Industry <b>Pharmacy</b>														
17. Father's Name (First, Middle, Last) <b>Joseph Daniel Terry</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Hattie Sue Jordan</b>																
19a. Informant's Name/Relationship (Type, Print) <b>Henry Wagstaff (Son)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>108 Enchanted Hills Rd. #203 Owings Mills, MD. 21117</b>																
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Jeters Chapel Cemetery</b>		Date <b>6/26/00</b>		20c. Location - City or Town, State <b>Omega, VA.</b>														
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Metropolitan Funeral Service 5517 Vine St. Alexandria, VA. 22310</b>																		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																						
<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>Cardiac Arrest</b></td> <td>Due to (or as a consequence of):</td> <td>20 min</td> </tr> <tr> <td>b. <b>Wound Sepsis</b></td> <td>Due to (or as a consequence of):</td> <td>7 months</td> </tr> <tr> <td>c. <b>End Stage Renal Disease</b></td> <td>Due to (or as a consequence of):</td> <td>10 yrs</td> </tr> <tr> <td>d. <b>Peripheral Vascular Disease</b></td> <td>Due to (or as a consequence of):</td> <td>10 yrs</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Cardiac Arrest</b>	Due to (or as a consequence of):	20 min	b. <b>Wound Sepsis</b>	Due to (or as a consequence of):	7 months	c. <b>End Stage Renal Disease</b>	Due to (or as a consequence of):	10 yrs	d. <b>Peripheral Vascular Disease</b>	Due to (or as a consequence of):	10 yrs
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a. <b>Cardiac Arrest</b>	Due to (or as a consequence of):	20 min																			
	b. <b>Wound Sepsis</b>	Due to (or as a consequence of):	7 months																			
	c. <b>End Stage Renal Disease</b>	Due to (or as a consequence of):	10 yrs																			
	d. <b>Peripheral Vascular Disease</b>	Due to (or as a consequence of):	10 yrs																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown														
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
				28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)														
				28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																						
29b. Signature and title of certifier 				29c. License number <b>12456</b>				29d. Date signed (Month, Day, Year) <b>June 22, 2000</b>														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Blaine Warkentine M.D. 22 South Green Street. Baltimore, MD. 21201</b>																						
31. Date filed (Month, Day, Year) <b>JUN 26 2000</b>				32. Registrar's Signature 																		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 22019

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Irene E. Titus

2. Date of Death

Month  
JuneDay  
26Year  
2000

3. Time of Death

9:30AM

4a. Facility Name (If not institution, give street and number)

Sacred Heart Home, Inc.

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

578-20-2943

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
03/02/1912

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

None

10b. County

None

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4520 River Road, N.W.

10f. Zip Code

20016

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Justin Peruzzi

18. Mother's Name (First, Middle, Maiden Surname)

Mary Earclauz

19a. Informant's Name/Relationship (Type, Print)

Robert Comstock/Attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5225 Wisc. Ave., N.W. #300 Wash. D.C. 20015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Date

June 29, 2000

20c. Location - City or Town, State

Washington, D.C.

21. Signature of Funeral Service Licensee

John F. DeLoe

22. Name and Address of Facility

DeVol Funeral Home  
2222 Wisc. Ave., N.W. Wash. D.C. 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute cerebrovascular accident

Approximate Interval Between Onset and Death

24 Hours

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Aortic stenosis

decades

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter M. Schisler MD

29c. License number

022780

29d. Date signed (Month, Day, Year)

6/27/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter M. Schisler MD 7500 Greenway Ctr. Dr. Greenbelt, Md 20770

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

Geneva B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22020

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ARNOLD J. TRANEN

2. Date of Death

6 24 2000

3. Time of Death

7:55 AM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

579-42-8449

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

02/08/33

9. Birthplace (State or Foreign Country)

Washington DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4925 Battery Lane

10f. Zip Code

20814

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Sam Tranen

18. Mother's Name (First, Middle, Maiden Surname)

Doria Bassin

19a. Informant's Name/Relationship (Type, Print)

Lorna Rae Tranen (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4925 Battery Lane Bethesda, MD 20814

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King David Memorial Garden 6-24-00 Falls Church, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Pearson Funeral Home

22. Name and Address of Facility

472 N. Washington St. Falls Church, VA 22046

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ARDS

Due to (or as a consequence of):

6H

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Sepsis

Due to (or as a consequence of):

5D

c. Adynamic ileus

Due to (or as a consequence of):

2W

d. Acute cholecystitis

1M

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, seizure disorder  
COPD, CAD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. H. H. H. H. H.

29c. License number

D48160

29d. Date signed (Month, Day, Year)

6/24/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETR HAVSNER, MD, 8001 Georgetown RD, BETHESDA, MD, 20817

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

Deneva B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.TRANEN, ARNOLD  
EXPIRED 6/24/00 at 7:55 AM  
Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22021

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alphonso M. Trapani</b>				2. Date of Death Month Day Year <b>June 24, 2000</b>		3. Time of Death <b>9:15 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>577-09-7004</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>October 3, 1914</b>		
	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>		
Usual Residence of Decedent		10d. Inside City Limits <b>1</b> Yes <b>2</b> No		10e. Street and Number <b>8618 Irvington Avenue</b>		10f. Zip Code <b>20817</b>		10g. Citizen of What Country? <b>United States</b>	
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager</b>		16b. Kind of Business/Industry <b>Grocery Store</b>					
17. Father's Name (First, Middle, Last) <b>Salvatore Trapani</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Caterina DiMisa</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Michael Trapani/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>109 Ednor Road, Silver Spring, Maryland 20905</b>					
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cemetery</b>		Data <b>June 28, 2000</b>		20c. Location - City or Town, State <b>Silver Spring, Maryland</b>			
21. Signature of Funeral Service Licensee <i>Michael E. Higgins</i> <b>M00846</b>		22. Name and Address of Facility <b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b>							
23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>Pulmonary Edema</b> Due to (or as a consequence of): <b>Cardiac Failure</b>		b. <b>Pulmonary Hypertension</b> Due to (or as a consequence of):		c. <b>1 Week</b>		d. <b>6 Months</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown		24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No		24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No			
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>8</b> Other (Specify)		27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Lewis N. Cahill</i>		29c. License number <b>D05256</b>		29d. Date signed (Month, Day, Year) <b>June 26, 2000</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Lewis N. Cahill, M.D., 6000 Executive Blvd., #300, Rockville, Maryland 20852-3803</b>		31. Date filed (Month, Day, Year) <b>JUN 28 2000</b>		32. Registrar's Signature <i>Bruce B. Sparks</i>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene 00 22022

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>REHENIA TURNBULL</b>				2. Date of Death Month Day Year <b>JUNE 28, 2000</b>		3. Time of Death <b>9:50 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>ST. THOMAS MORE NURSING HOME</b>				4b. City, Town, or Location of Death <b>HYATTSVILLE</b>		4c. County of Death <b>PRINCE GEORGES</b>		
Funeral Director	5. Social Security Number <b>134-32-4302</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>JUNE 4, 1913</b>		
	9. Birthplace (State or Foreign Country) <b>TORTALA, B.V.I.</b>		10a. State <b>MD.</b>		10b. County <b>PRINCE GEORGES</b>		10c. City, Town or Location <b>HYATTSVILLE</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4922 LaSALLE RD.</b>		10f. Zip Code <b>20782</b>		10g. Citizen of What Country? <b>U.S.V.I.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>DOMESTIC</b>		16b. Kind of Business/Industry <b>PRIVATE HOMES</b>		17. Father's Name (First, Middle, Last) <b>ANDREW C. FRASER</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ALPHERA THOMAS</b>	
19a. Informant's Name/Relationship (Type, Print) <b>MARY TURNBULL/DAUGHTER-IN-LAW</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2002 AMHERST RD., HYATTSVILLE, MD. 20783</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WESTERN CEMETERY</b>		20c. Location - City or Town, State <b>7/8/00 ST. THOMAS, V.I.</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i> MO0091		22. Name and Address of Facility <b>CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Multiple organ failure</b> Due to (or as a consequence of): <b>&gt; months</b> b. <b>Breast cancer with metastasis</b> Due to (or as a consequence of): <b>&gt; 2 yrs.</b> c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D19609</b>		29d. Date signed (Month, Day, Year) <b>6-29-00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. RAMEN TULI, M.D. 3503 PERRY ST., MT. RAINIER, MD. 20712</b>		31. Date filed (Month, Day, Year) <b>JUN 30 2000</b>		32. Registrar's Signature <i>[Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22023

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Louis A. Vagnoni</b>				2. Date of Death Month <b>June</b> Day <b>29</b> Year <b>2000</b>		3. Time of Death <b>1:10A.</b>	
	4a. Facility Name (If not institution, give street and number) <b>3100 Chapel View Drive</b>				4b. City, Town, or Location of Death <b>Beltsville</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>579-20-9510</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>April 14, 1923</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, D.C.</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Beltsville</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3100 Chapel View Drive</b>		10f. Zip Code <b>20705</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Personnel Officer</b>		16b. Kind of Business/Industry <b>United States Navy</b>				
17. Father's Name (First, Middle, Last) <b>Orazio Vagnoni</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Carmela Capone</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Martha B. Vagnoni (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		Date <b>7/3/2000</b>		20c. Location - City or Town, State <b>Brentwood, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Donald V. Borgwardt</b>		22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>						
23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>CARCINOMA LUNG</b> Due to (or as a consequence of): b. <b>BRAIN METASTASIS</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.								
Approximate Interval Between Onset and Death <b>3-4-99</b> <b>12-6-99</b>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Stano</b>		29c. License number <b>D0013668</b>		29d. Date signed (Month, Day, Year) <b>June 29, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Azher Hussain, M.D. 4917 Edgewood Road College Park, Maryland 20740</b>								
31. Date filed (Month, Day, Year) <b>JUN 30 2000</b>		32. Registrar's Signature <b>B. Sparks</b>						





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State of Maryland / Department of Health and Mental Hygiene

00 22024

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anna Belle van Muyden</b>				2. Date of Death Month Day Year <b>June 23, 2000</b>		3. Time of Death <b>9:45 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>Suburban Hospital</b>				4b. City, Town, or Location of Death <b>Bethesda</b>		4c. County of Death <b>Montgomery</b>		
Funeral Director	5. Social Security Number <b>197-14-6577</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Apr 12, 1925</b>		9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Bethesda</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>4518 Gretna Street</b>				10f. Zip Code <b>20814</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Walter D. Soles</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Ross</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Colleen McLachlen (Daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10 Sausilito Court Annapolis, MD 20143</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Rock Creek Cemetery</b>		Date <b>06/27</b>		20c. Location - City or Town, State <b>Washington, DC</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>JOSEPH GAWLER'S SONS, INC. 5130 Wisconsin Ave., NW Washington, DC 20016</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  <div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. <b>Hypoglycemic Encephalopathy</b> Due to (or as a consequence of):</p> <p>b. <b>Diabetes Mellitus</b> Due to (or as a consequence of):</p> <p>c. <b>Hypertension</b> Due to (or as a consequence of):</p> <p>d. <b>Chronic Obstructive Pulmonary Disease</b></p> </div> </div>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <b>M. Linda M. Thompson MD</b>				29c. License number <b>D44025</b>		29d. Date signed (Month, Day, Year) <b>6/23/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. LINDA M. THOMPSON MD, 11125 ROCKVILLE PIKE, SUITE 103, ROCKVILLE MD 20852</b>									
31. Date filed (Month, Day, Year) <b>JUN 26 2000</b>		32. Registrar's Signature 							





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22025

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Elbert Leon Virts

2. Date of Death

June 26, 2000

3. Time of Death

12:55 am

4a. Facility Name (If not institution, give street and number)

Montgomery General Hospital

4b. City, Town, or Location of Death

Olney

4c. County of Death

Montgomery

5. Social Security Number

213-16-2579

8. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Dec 30, 1918

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

15115 Interlachen Dr. Apt 207

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1944-

1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Purchasing Supervisor

16b. Kind of Business/Industry

John Hopkins Applied

Physics Lab

17. Father's Name (First, Middle, Last)

Elbert Joseph Virts

18. Mother's Name (First, Middle, Maiden Surname)

Lela C. Smith

19a. Informant's Name/Relationship (Type, Print)

Vivian Virts / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15115 Interlachen Dr., Apt 207, Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

6/29/00

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

William L. Byrd

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. NOW SMALL CELL LUNG CANCER

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

3 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Joseph K. Kram

29c. License number

D35635

29d. Date signed (Month, Day, Year)

June 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Kram 1311 Prima Philip Dr Olney, MD 20832

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

Geneva B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22026

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Richard Wagner, Sr.

2. Date of Death

Month Day Year  
June 22, 2000

3. Time of Death

1347

4a. Facility Name (If not institution, give street and number)

Dorchester General Hospital

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

216-22-9328

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Feb 1, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2559 Albert Rill Road

10f. Zip Code

21157

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
7

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Home Building

17. Father's Name (First, Middle, Last)

Marshall C. Wagner

18. Mother's Name (First, Middle, Maiden Surname)

Georgia V. Rupp

19a. Informant's Name/Relationship (Type, Print)

Carrie Wagner, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2559 Albert Rill Rd, Westminster, MD 21157

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wesley Cemetery

Date

6/25

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

Stewart W. Glau M00723

22. Name and Address of Facility

Eline Funeral Home  
934 South Main St, Hampstead, MD 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. History of Coronary Artery Disease

Due to (or as a consequence of):

12 mo

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Michael F. Glau

29c. License number

D26388

29d. Date signed (Month, Day, Year)

6-22-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael F. Glau MD 302 Collins Hurlock MD 21643

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22027

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Arthur William Weaver</b>				2. Date of Death Month Day Year <b>June 22, 2000</b>		3. Time of Death <b>12:50 am</b>		
	4a. Facility Name (If not institution, give street and number) <b>Long View Nursing Home</b>				4b. City, Town, or Location of Death <b>Manchester</b>		4c. County of Death <b>Carroll</b>		
Funeral Director	5. Social Security Number <b>213-03-0639</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Mar 16, 1917</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Carroll</b>	10c. City, Town or Location <b>Hampstead</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>3927 Shiloh Avenue</b>			10f. Zip Code <b>21074</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dispatcher</b>			16b. Kind of Business/Industry <b>Baltimore Gas &amp; Electric Co</b>			
	17. Father's Name (First, Middle, Last) <b>Wilbert Weaver</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lula Ebaugh</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Bonnie Greenholtz, step-daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3927 Shiloh Ave, Hampstead, MD 21074</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hampstead Cemetery</b>		Date <b>6/24</b>		20c. Location - City or Town, State <b>Hampstead, MD</b>		
	21. Signature of Funeral Service Licensee <i>Sharon W. Eline</i> M00723		22. Name and Address of Facility <b>Eline Funeral Home 934 South Main St, Hampstead, MD 21074</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Chronic obstructive pulmonary disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>Chronic renal insufficiency</b> Due to (or as a consequence of):								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic renal insufficiency</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <b>D37573</b>		29d. Date signed (Month, Day, Year) <b>June 27, 2000</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Jeff Zbell 7020 Park Heights Ave Baltimore MD 21202</b>									
31. Date filed (Month, Day, Year) <b>JUN 26 2000</b>		32. Registrar's Signature <i>[Signature]</i>							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22028

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MYRTLE VIRGINIA WINDSOR

2. Date of Death

JUNE 28, 2000

3. Time of Death

4:50 PM

4a. Facility Name (If not institution, give street and number)

15620 ST. THOMAS CHURCH ROAD

4b. City, Town, or Location of Death

UPPER MARLBORO

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director

5. Social Security Number

218-24-0495

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV. 1, 1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15620 St. Thomas Church Road

10f. Zip Code

20772

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John Francis Thomas

18. Mother's Name (First, Middle, Maiden Surname)

Martha Ann Beatly

19a. Informant's Name and Relationship (Type, Print)

Ronnie E. Windsor/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15620 St. Thomas Church Rd., Upper Marlboro, MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Thomas Cemetery

Date

07-03-2000

20c. Location - City or Town, State

Croom, Maryland

21. Signature of Funeral Service Licensee

MARK G. BROHAWN MO0053

22. Name and Address of Facility

THE HUNTT FUNERAL HOME, INC.  
P.O. BOX 156, WALDORF, MARYLAND 20604

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Decompensated cirrhosis, cryptogenic

Approximate Interval Between Onset and Death

8 months

Due to (or as a consequence of):

b. Ascites

8 months

Due to (or as a consequence of):

c. hepatic encephalopathy

4 months

Due to (or as a consequence of):

d. chronic obstructive pulmonary disease

10 + years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alain G. Champaloux MD

29c. License number

D42049

29d. Date signed (Month, Day, Year)

JUNE 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alain G. CHAMPALOUX MD. Upper Marlboro Md. 20772

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

Denise B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22029

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Francis Wooten

2. Date of Death

June 23, 2000

3. Time of Death

11:30 PM

4a. Facility Name (If not institution, give street and number)

11506 Accolade Terrace

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

402-22-4489

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 6, 1925

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11506 Accolade Terrace

10f. Zip Code

21213

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Letter Carrier

16b. Kind of Business/Industry

U.S. Postal Service

17. Father's Name (First, Middle, Last)

George Nelson Wooten

18. Mother's Name (First, Middle, Maiden Surname)

Cleo Boone

19a. Informant's Name/Relationship (Type, Print)

Larry Wooten - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11506 Accolade Terrace Clinton, MD 21213

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Calvary Cemetery

Date

6-26-2000

20c. Location - City or Town, State

Shelbyville, KY

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Metropolitan Funeral Service, Inc.

5517 Vine Street Alexandria, VA 22310

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Louis V. Kaufman, MD

29c. License number

D12906

29d. Date signed (Month, Day, Year)

6/26/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Louis V. Kaufman, MD 9131 Piscataway Road Clinton, MD

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22030

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Steven Willson

2. Date of Death

June 25, 2000

3. Time of Death

10:15 am

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

9907 Capital View Avenue

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

216-60-0635

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)

Sep 21, 1951

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9907 Capital View Avenue

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Goldsmith

16b. Kind of Business/Industry

Jewelry Retail

17. Father's Name (First, Middle, Last)

James Robert Willson

18. Mother's Name (First, Middle, Maiden Surname)

Susan L. Burner

19a. Informant's Name/Relationship (Type, Print)

Mary S. Willson / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9907 Capital View Avenue, Silver Spring, MD 20910

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

6/30/00

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiopulmonary Failure

Acute

Due to (or as a consequence of):

b. Pleural Effusion/ Pulmonary Metastatic

Chronic

Due to (or as a consequence of):

c. Renal Cancer

Chronic

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 53177

29d. Date signed (Month, Day, Year)

June 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Wallmark, MD 9707 Medical Park Drive, Rockville, MD 20850

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

John B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22031

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH WHITTINGTON

2. Date of Death

June 23, 2000

3. Time of Death

2:40 am

4a. Facility Name (If not Institution, give street and number)

Springbrook Adventist Nursing &amp; Rehab.

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577-36-1293

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

98 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Apr 23, 1902

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Adelphi

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2514 Hughes Road

10f. Zip Code

20783

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Sales Clerk

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Walter Stephenson

18. Mother's Name (First, Middle, Maiden Surname)

Mary McClure

19a. Informant's Name/Relationship (Type, Print)

Betty Jane Pruitt / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2514 Hughes Road, Adelphi, MD 20783

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

George Washington Cemetery 2000

Date

7/3/

20c. Location - City or Town, State

Adelphi, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

many years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31001

29d. Date signed (Month, Day, Year)

6/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STUART T. TURKEWITZ, MD 7500 GREENWAY CTR. DR. #430 GREENBELT, MD 20770

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22032

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marguerite Estelle Ward

2. Date of Death

Month Day Year  
June 27, 2000

3. Time of Death

3:01 am

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

214-14-5974

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Mar 1, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

321 University Blvd., West Apt 127

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Clerical

17. Father's Name (First, Middle, Last)

William C. Folsom

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Marguerite Schultze

19a. Informant's Name/Relationship (Type, Print)

Loretta M. Sutton / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20808 Brooke Knolls Road, Laytonsville, MD 20882

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parklawn Memorial Park

Date

6/30/00

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W, Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

MONTHS

Due to (or as a consequence of):

b. MITRAL REGURGITATION

~2 YEARS

Due to (or as a consequence of):

c. RADIATION THERAPY

~2 YEARS

Due to (or as a consequence of):

d. CARCINOID TUMOR OF THE LUNG

~2 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PLEURAL EFFUSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

VENTRICULAR TACHYCARDIA

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D25344

29d. Date signed (Month, Day, Year)

6/27/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert J. GINSBERG, MD 2415 MUSGROVE RD #209 SILVER SPRING, MD 20904

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22033

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Robert Ingersoll Waite</b>				2. Date of Death Month Day Year <b>June 26, 2000</b>		3. Time of Death <b>8:02 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>11704 Lytle Street</b>				4b. City, Town, or Location of Death <b>Wheaton</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>079-16-8613</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>86</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov 28, 1913</b>	9. Birthplace (State or Foreign Country) <b>New York</b>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>	10b. County <b>Montgomery</b>	10c. City, Town or Location <b>Wheaton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>11704 Lytle Street</b>			10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Information Officer</b>		16b. Kind of Business/Industry <b>Defence Mapping Agency</b>			
	17. Father's Name (First, Middle, Last) <b>Benjamin Franklin Waite</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Eloise Snell</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Lovena A. Smith / Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13710 Highland Road, Clarksville, MD 21029</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Date <b>6/30/00</b>		20d. Location - City or Town, State <b>Alexandria, VA</b>	
	21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) a. <b>Coronary Heart Disease</b> years Due to (or as a consequence of): b. <b>Atherosclerotic Cardiovascular Disease</b> years Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 			29c. License number <b>225808</b>		29d. Date signed (Month, Day, Year) <b>6/27/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Herman Segal, MD 10313 Georgia Ave., #307, Silver Spring, MD 20902</b>								
31. Date filed (Month, Day, Year) <b>JUN 28 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22034

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) Annie J. Whiteman				2. Date of Death Month Day Year June 28 2000		3. Time of Death 6:40 AM	
4a. Facility Name (If not institution, give street and number) Goodwill Mennonite Home				4b. City, Town, or Location of Death Grantsville		4c. County of Death Garrett	
5. Social Security Number 215-05-2939		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12/11/05	
9. Birthplace (State or Foreign Country) MD							
Usual Residence of Decedent							
10a. State MD		10b. County Garrett		10c. City, Town or Location Grantsville		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
10e. Street and Number P. O. Box 310				10f. Zip Code 21536		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Housewife		16b. Kind of Business/Industry Own Home	
17. Father's Name (First, Middle, Last) Nelson Wilt				18. Mother's Name (First, Middle, Maiden Surname) Fannie Burkholder			
19a. Informant's Name/Relationship (Type, Print) Charles Lancaster				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 187 Montague Road, Addison, PA 15411			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baptist Cemetery		Date 06/30/00		20c. Location - City or Town, State Confluence, PA	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Humbert Funeral Home P. O. Box 37, Confluence, PA 15424			
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Heart Failure Due to (or as a consequence of): b. Coronary Artery Disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 1 year 5 years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Previous Stroke.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number D 34079		29d. Date signed (Month, Day, Year) June 29, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James E. Berlino Grantsville MD 21536							
31. Date filed (Month, Day, Year) JUL 11 2000		32. Registrar's Signature 					

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22035

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARVA</b>		2. Date of Death Month <b>June</b> Day <b>21</b> Year <b>2000</b>		3. Time of Death <b>11:50 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>N/A</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>6-21-2000</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County		10c. City, Town or Location <b>Baltimore, Maryland</b>	
10e. Street and Number <b>1742 E. Oliver Street</b>		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>	
16b. Kind of Business/Industry <b>N/A</b>		17. Father's Name (First, Middle, Last) <b>Unknown</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Nicole Winchester</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Nicole Winchester/mother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1742 E. Oliver St - Balto. Md. 21213</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Disposal</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Johns Hopkins Hospital</b>		20c. Location - City or Town, State <b>Baltimore, Md. 21287</b>	
21. Signature of Funeral Service Licensee <b>Rebecca Evans</b>		22. Name and Address of Facility <b>SHH- 600 N. Wolfe St.</b>			
23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>EXTREME PREMATURITY</b> Due to (or as a consequence of):			Approximate Interval Between Onset and Death <b>1 HOUR</b>
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. Due to (or as a consequence of):			
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHORIOAMNIONITIS</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Rachira Garg</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>JUNE TWENTY FIRST, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RACHIRA GARG JOHN'S HOPKINS HOSPITAL 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21287</b>					
31. Date filed (Month, Day, Year) <b>JUL 11 2000</b>		32. Registrar's Signature <b>Benita S. Sparks</b>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22036

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Libbie

Zucker

2. Date of Death

Month Day Year  
June 24, 2000

3. Time of Death

7:45 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

5901 Montrose Road Apt. 1608 N

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

045-14-8474

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 29, 1911

9. Birthplace (State or Foreign Country)

Baltimore, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5901 Montrose Road Apt. 1608 N

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)  
5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Guidance

17. Father's Name (First, Middle, Last)

Morris S. Dunn

18. Mother's Name (First, Middle, Maiden Summe)

Rosa Kallinsky

19a. Informant's Name/Relationship (Type, Print) (Daughter)

Dr. Rebecca Z. Hertzman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12103 Devilwood Drive Potomac, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Beth Alom

Date

6/26/00

20c. Location - City or Town, State

New Britain, CT

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Metropolitan Funeral Service, Inc.

5517 Vine Street Alexandria, VA 22310

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Colon cancer  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5901 Montrose Rd #1608N

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0016115

29d. Date signed (Month, Day, Year)

6/24/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marc Hertzman MD 11404 Old Georgetown Rd, Rockville MD 20852

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22037

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Joseph Henry Brecht</i>		2. Date of Death Month <i>July</i> Day <i>6</i> Year <i>2000</i>		3. Time of Death <i>9:40am</i>	
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Systems</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>n/a</i>	
Funeral Director	5. Social Security Number <i>215-42-9574</i>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <i>55</i> Yrs.	8. Date of Birth (Month, Day, Year) <i>Sept. 16, 1944</i>	9. Birthplace (State or Foreign Country) <i>Maryland</i>	
	Usual Residence of Decedent					
To Be Completed by Funeral Director	10a. State <i>Maryland</i>	10b. County <i>n/a</i>	10c. City, Town or Location <i>Baltimore</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <i>3205 Strickland Street</i>		10f. Zip Code <i>21229</i>	10g. Citizen of What Country? <i>United States</i>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>1968-71</i>	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>0</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>lathe operator</i>		16b. Kind of Business/Industry <i>rubber</i>	
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <i>Louis Henry Brecht, Jr.</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Alice America Dixon</i>			
	19a. Informant's Name/Relationship (Type, Print) <i>Marlene E. Brecht - wife</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3205 Strickland Street, Baltimore, Maryland 21229</i>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Baltimore National Cemetery</i>		20c. Location - City or Town, State <i>7/10/00 Baltimore, Maryland</i>	
	21. Signature of Funeral Service Licensee <i>Ann Y. Zink</i>		22. Name and Address of Facility <i>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229</i>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <i>Coronary Artery Disease</i> Due to (or as a consequence of): <i>Anoxic Brain Injury</i> Due to (or as a consequence of): <i>Multiple Organ System Failure</i> Due to (or as a consequence of):				Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury <i>M</i>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>A44176435712457</i>		29d. Date signed (Month, Day, Year) <i>July 7, 2000</i>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Jon Yamaguchi 22 South Greene Street Baltimore, Maryland 21201</i>					
	31. Date filed (Month, Day, Year) <i>JUL 12 2000</i>	32. Registrar's Signature <i>[Signature]</i>				

ORIGINAL

00 55031



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22038

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Adeline Elizabeth Batzer

2. Date of Death

Month Day Year  
July 6 2000

3. Time of Death

2250

4a. Facility Name (If not institution, give street and number)

Atlantic General Hospital

4b. City, Town, or Location of Death

Berlin

4c. County of Death

Worcester

Funeral  
Director

5. Social Security Number

217-26-0084

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

93

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jul 29, 1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Delaware

10b. County

Sussex

10c. City, Town or Location

Frankford

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

Rt 2 Box 133-H

10f. Zip Code

19945

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George Clements

18. Mother's Name (First, Middle, Maiden Surname)

Justine Krause

19a. Informant's Name/Relationship (Type, Print)

Mildred M. Elderkin / daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rt 2, Box 133H, Frankford, Delaware 19945

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Loudon Park Cemetery

Date

7/11/2000 Baltimore, Maryland

21. Signature of Funeral Service Licensee

Ann Y. Zink

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RENAL FAILURE

Due to (or as a consequence of):

b. DIGOXIN TOXICITY

Due to (or as a consequence of):

c. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

d. CORONARY HEART DISEASE

Approximate Interval Between Onset and Death

6/29/00

7/2/00

6/29/00

8 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D46257

29d. Date signed (Month, Day, Year)

7/7/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9704 Heathway Drive Berlin, MD 21811

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Batzer, Adeline 217-26-0084  
Baltimore, Maryland 21215-0020  
Exp 7/6/00 @ 2025  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2025.



80055 00

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22039

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elaine K. Brightbill

2. Date of Death  
Month Day Year  
JULY 09, 20003. Time of Death  
13:50 PM

4a. Facility Name (If not institution, give street and number)

ROUTE 50 AT BUCK BRYAN ROAD

4b. City, Town, or Location of Death

4c. County of Death

TALBOT

Funeral  
Director

5. Social Security Number

210-40-1499

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 31, 1949

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

PA

10b. County

Perry Co.

10c. City, Town or Location

660 Mountain Road

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

660 Mountain Road

10f. Zip Code

17062

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Hairdresser

16b. Kind of Business/Industry

Beauty

17. Father's Name (First, Middle, Last)

Chester Killheffer

18. Mother's Name (First, Middle, Maiden Surname)

Jean Ricker

19a. Informant's Name/Relationship (Type, Print)

M. Donald Brightbill

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

660 Mountain Road, Millerstown, PA 17062

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pfoutz Valley U.M. Cem.

Date

7/15/00

20c. Location - City or Town, State

Millerstown, PA

21. Signature of Funeral Service Licensee

Jhm Schlanger MD

22. Name and Address of Facility

Witzke Funeral Homes, Inc.  
1630 Edmondson Avenue, Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

MULTIPLE INJURIES

b.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

7/9/00 FOUND

28b. Time of Injury

FOUND

1344 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUBJECT DRIVEN OFF CAR WHICH STRUCK FIXED OBJECT

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ROADWAY

28f. Location (Street and Number or Rural Route Number, City or Town, State)

RT. 50 AT BUCK BRYAN ROAD

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Jhm Schlanger MD

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JULY 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY G. RIPLE, M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

Jhm Schlanger MD

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME

Division of Vital Records, P.O. Box 68760,

2011



RVNE



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22040

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Albert William Buchwald, Sr.

2. Date of Death

Month Day Year  
July 10, 2000

3. Time of Death

6:05 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

9 North Prospect Avenue

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

5. Social Security Number

216-07-0416

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

84

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 7, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9 North Prospect Avenue

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates.13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Pharmacy

17. Father's Name (First, Middle, Last)

Philip C. Buchwald

18. Mother's Name (First, Middle, Maiden Surname)

Louise Wiessner

19a. Informant's Name/Relationship (Type, Print)

Louise Mathis/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Rural Rt 4, Box 320-E, Sneedville, Tennessee 37869

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Woodlawn Cemetery

Date

7/12/00

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

► *Theresa L. Lemmer*

M00741

22. Name and Address of Facility

Witzke Funeral Homes, Inc.  
1630 Edmondson Avenue, Catonsville, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)*Cardiac arrest of the lung.*

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last*Emphysema*

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Myocardial Infarct.**Coronary Heart Failure*

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be  
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► *Myraudis L. Lerner*

29c. License number

D0008780

29d. Date signed (Month, Day, Year)

July 10-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*ALEJANDRO MEJIA MD 405 Frederick Rd. Baltimore 21228*State  
Registrar

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

*B. Sparks*

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-251-1000.Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22041

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALLUSTUS D. BROWN

2. Date of Death  
Month Day Year  
JULY 08 20003. Time of Death  
12:25P

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

216-54-6118

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

12-31-49

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3307 SPRINGDALE AVE

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DISABLED

16b. Kind of Business/Industry

DISABLED

17. Father's Name (First, Middle, Last)

FLOYD W. DUFFY

18. Mother's Name (First, Middle, Maiden Surname)

ELMA BAKER

19a. Informant's Name/Relationship (Type, Print)

TANYA QUEEN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3307 SPRINGDALE AVE, BALTO. MD 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MOUNT ZION

Date

7-13-00

20c. Location - City or Town, State

LANSDOWNE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howell Funeral Home

4600 LIBERTY HGHTS AVE, BALTO, MD 21207

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 HOUR

b. HYPERKALEMIA

Due to (or as a consequence of):

24 HOURS

c. END-STAGE RENAL FAILURE

Due to (or as a consequence of):

UNK

d. DIABETES

UNK

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D25379

29d. Date signed (Month, Day, Year)

JULY 08, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN L. JOFFE, MD SINAI HOSPITAL 2142 W. BELVEDERE AVE, BALTO. 21215

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature


State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

210000 01



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22042

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Charles Bongiovano

2. Date of Death

Month Day Year  
July 5, 2000

3. Time of Death

10:40 pm

4a. Facility Name (If not institution, give street and number)

974 Punjab Circle

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

5. Social Security Number

217-16-4802

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 3, 1923

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

ESSEX

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

974 Punjab Circle

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Margaret DeLuca

19a. Informant's Name/Relationship (Type, Print)

John Bongiovano - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

974 Punjab Circle Baltimore, Maryland 21221

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Baltimore-Washington Crematory

7/8/00

Date

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Charles S. Zeiler &amp; Son, Inc.

6224 Eastern Avenue Baltimore, Maryland 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. METASTATIC ADENOCARCINOMA OF UNKNOWN ORIGIN 1 year  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Pending investigation☐ Accident☐ Suicide☐ Homicide☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)☒ Certifying Physician☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33551

29d. Date signed (Month, Day, Year)

July 6, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael AUERBACH, 9000 FRANKLIN SQ. Dr. Baltimore 21237

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

2008-2009

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28ASF PER MEO G785-7-26-00 WR

Certificate of Death

Reg. No.

00 22043

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Tyrone Anthony Christian				2. Date of Death Month Day Year July 08, 2000				3. Time of Death 810 am	
	4a. Facility Name (If not institution, give street and number) 2441 Edmondson Avenue				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A	
Funeral Director	5. Social Security Number 216-58-2098		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) Mar 26, 1953		9. Birthplace (State or Foreign Country) MD		10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore	
Usual Residence of Decedent		10a. Street and Number 5013 Midwood Avenue		10f. Zip Code 21212		10g. Citizen of What Country? United States		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 12		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Maintenance		17. Father's Name (First, Middle, Last) John Edward Christian		18. Mother's Name (First, Middle, Maiden Surname) Jean Loiss Johnson		19a. Informant's Name/Relationship (Type, Print) Mrs. Roslyn Synder-Sister		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5013 Midwood Avenue, Baltimore, MD 21212		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mount Zion Cemetery		Date Jul 15 2000		20c. Location - City or Town, State Baltimore, MD		
21. Signature of Funeral Service Licensee Calvin L. Williams		22. Name and Address of Facility Smith & Williams Funeral Home, P.A. 2818 East Baltimore Street Baltimore, MD		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. Signature and title of certifier Maurice Drelhell		29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) July 09, 2000		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mrs. Roslyn Synder-Sister 111 Penn Street, Baltimore, Maryland 21201		31. Date filed (Month, Day, Year) JUL 11 2000		
32. Registrar's Signature		33. Registrar's Signature		34. Registrar's Signature		35. Registrar's Signature		36. Registrar's Signature		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22044

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles J. Constantino

2. Date of Death

Month  
JULYDay  
7Year  
2000

3. Time of Death

11:18 PM

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

212-30-7938

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 10, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

423 S. Bentalou Street

10f. Zip Code

21223

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

cashier/stock clerk

16b. Kind of Business/Industry

grocery store

17. Father's Name (First, Middle, Last)

Charles R. Constantino

18. Mother's Name (First, Middle, Maiden Surname)

Harriet J. Amey

19a. Informant's Name/Relationship (Type, Print)

Vivian A. England - sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

423 S. Bentalou Street, Baltimore, Maryland 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)  
Loudon Park Cemetery

Date

7/10/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Ann Y. Zink

22. Name and Address of Facility

Hubbard Funeral Home, Inc.  
4107 Wilkens Avenue  
Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

UNKNOWN

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. [Signature] MD

29c. License number

P19600

29d. Date signed (Month, Day, Year)

JULY, 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NASSER NASSERI ST. AGNES HOSPITAL 900 CATON AVE BALTIMORE MD

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

[Signature] Sparks

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2024.

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitNAME CHARLES CONSTANTINO  
Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22045

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Harlin W. Crandall Jr.				2. Date of Death Month: JUNE Day: 25 Year: 2000				3. Time of Death 18:16 PM		
	4a. Facility Name (If not Institution, give street and number) 11410 SHERRI LANE				4b. City, Town, or Location of Death SILVER SPRING				4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 579-48-3207		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 66 Yrs.		8. Date of Birth (Month, Day, Year) 9-10-1933		9. Birthplace (State or Foreign Country) Washington D.C.		
	Usual Residence of Decedent										
10a. State Md		10b. County Montgomery		10c. City, Town or Location Silver Spring				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
10e. Street and Number 11410 Sherri Lane				10f. Zip Code 20902				10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Sales				16b. Kind of Business/Industry Insurance			
17. Father's Name (First, Middle, Last) Harlin W. Crandall, Sr.					18. Mother's Name (First, Middle, Maiden Surname) Mary A. (unavailable)						
19a. Informant's Name/Relationship (Type, Print) Donna Beckford cousin				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12805 S. Indian River Drive Jensen Beach, Fl. 34957							
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington Crem.		Date 7-3-00		20c. Location - City or Town, State Laurel, Maryland			
21. Signature of Funeral Service Licensee <i>Shonda L. Lemmer</i> M00741				22. Name and Address of Facility Fleck Funeral Home INC. 7601 Sandy Spring Road Laurel, Maryland 20707							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>Hypertensive atherosclerotic Cardiovascular disease</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic obstructive pulmonary disease</u>										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <u>Limited</u> 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>SCENE</u>							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>Stephen S. Radentz</i>				29c. License number O.C.M.E.				29d. Date signed (Month, Day, Year) JUNE 26, 2000			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Stephen S. Radentz</i> 111 Penn Street, Baltimore, Maryland 21201											
31. Date filed (Month, Day, Year) JUL 12 2000										32. Registrar's Signature <i>[Signature]</i>	

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, R  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22046

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frances Elizabeth Clements</b>				2. Date of Death Month <b>7</b> Day <b>7</b> Year <b>2000</b>				3. Time of Death <b>1:52 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>4630 Rokeby Rd.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>216-24-0382</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.	
	8. Date of Birth (Month, Day, Year) <b>01 25-1926</b>		9. Birthplace (State or Foreign Country) <b>North Carolina</b>		10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
Usual Residence of Decedent		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>4630 Rokeby Rd.</b>		10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1st</b> College (1-4or 5+) <b></b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Domestic</b>		17. Father's Name (First, Middle, Last) <b>Joseph Ray</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Elnora Ray</b>		19a. Informant's Name/Relationship (Type, Print) <b>Joyce Handy (Daughter)</b>		
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4630 Rokeby Rd. Balto., Md. 21229</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery</b>		20c. Location - City or Town, State <b>7-14-00 Balto., Md. 21229</b>		21. Signature of Funeral Service Licensee <b>Dennis B. Caple</b>		
22. Name and Address of Facility <b>Caple Funeral Service</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory Failure</b> Due to (or as a consequence of): <b>b. Pulmonary Hypertension</b> Due to (or as a consequence of): <b>c. Interstitial Chronic Alveolar Lung Disease</b> Due to (or as a consequence of): <b>d. Disease</b>		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>7-11-2000</b>		
28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>A. M. Elia</b>		29c. License number <b>D-0008780</b>		29d. Date signed (Month, Day, Year) <b>7-11-2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A. M. Elia 405 Frederick Rd. Baltimore 21228.</b>		
31. Date filed (Month, Day, Year) <b>JUL 12 2000</b>		32. Registrar's Signature <b>A. M. Elia</b>		33. State Registrar		34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020		35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.		

ORIGINAL

*[Faint, illegible handwriting throughout the page]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22047

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret

Callahan

2. Date of Death

Month Day Year  
July 11, 2000

3. Time of Death

8:00 A.M.

4a. Facility Name (If not institution, give street and number)

4016 Bellwood Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-46-2451

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

97

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
9/16/1902

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

4016 Bellwood Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John McGuire

18. Mother's Name (First, Middle, Maiden Surname)

Mary Harmeyer

19a. Informant's Name/Relationship (Type, Print)

Dorothy Callahan/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4016 Bellwood Avenue Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holy Redeemer Cemetery

Date

7/15/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility John C. Miller Inc.

6415 Belair Road Baltimore, Maryland 21206

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

b. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c.

Due to (or as a consequence of):

d.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 YRS

15-20 YRS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

29c. License number

D 0018662

29d. Date signed (Month, Day, Year)

7/11/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. William Goldiner 5901 Harford Rd Suite B Baltimore MD 21214

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-0020.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 22048

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elaine Davis

2. Date of Death

Month Day Year  
July 04 2000

3. Time of Death

06:51 P.M.

4a. Facility Name (If not institution, give street and number)

912 High Street

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

Funeral  
Director

5. Social Security Number

215-64-9261

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 25, 1951

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Cambridge

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

912 High Street Ext.

10f. Zip Code

21613

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Benjamin Davis

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Davis

19a. Informant's Name/Relationship (Type, Print)

James Pinder, Jr.-Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

312 Crusaders Rd Apt. 201 Cambridge, MD 21613

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Mem. Pk.

Date

Jul 11 2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Smith & Williams Funeral Home, P.A.  
2818 East Baltimore Street Baltimore, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Morbid obesity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Scene

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 6, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,







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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 22049

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Amelia Lucy Davis				2. Date of Death Month Day Year July 9 2000				3. Time of Death 12:45 PM	
	4a. Facility Name (If not institution, give street and number) Catonsville Commons				4b. City, Town, or Location of Death Catonsville				4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 228-34-9788		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 76		8. Date of Birth (Month, Day, Year) Sep 18, 1923		9. Birthplace (State or Foreign Country) Virginia	
	Usual Residence of Decedent				10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 1110 Carroll Street				10f. Zip Code 21230		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Frank Jones				18. Mother's Name (First, Middle, Maiden Surname) Lucy (Unknown)					
	19a. Informant's Name/Relationship (Type, Print) David Smithson / son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 540 S. Bentalou Street, Baltimore, Maryland 21223					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		20c. Location - City or Town, State 7/11/2000 Elkridge, Maryland					
	21. Signature of Funeral Service Licensee Ann Y. Zink				22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) a. SMALL CELL CARCINOMA LUNG Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death YES					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier K. TONIE MD				29c. License number D20333		
29d. Date signed (Month, Day, Year) 7/11/00				30. Name and address of person who completed cause of death (with 23a) (Type, Print) K. TONIE MD 1838 GREENBRIER RD Pikesville MD 21208						
31. Date filed (Month, Day, Year) JUL 12 2000		32. Registrar's Signature S. Sparks								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22050

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

REESE E. DUKES

2. Date of Death

JUL 5 00

3. Time of Death

6:35 PM

4a. Facility Name (If not institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral  
Director

5. Social Security Number

222-22-5384

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug 31, 1922

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6336 Cedar Lane

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 43-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

college professor

16b. Kind of Business/Industry

education

17. Father's Name (First, Middle, Last)

John R. Dukes

18. Mother's Name (First, Middle, Maiden Surname)

Mariam Hastings

19a. Informant's Name/Relationship (Type, Print)

Harriette Dukes, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6336 Cedar Lane, Columbia, Md. 21044

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore/Washington Crem. 7/8/00 Laurel, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

► Thanda L Lemmer

MO0741

22. Name and Address of Facility

Witzke Funeral Homes, Inc.  
5555 Twin Knolls Rd., Columbia, Md. 21045

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR FIBRILLATION

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

IMMEDIATE

YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Methicillin resistant staphylococcus aureus respiratory infection, Prostate cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► [Signature]

29c. License number

D38296

29d. Date signed (Month, Day, Year)

JUL 7, 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH GIBBONS, MD 9501 OLD ANNAPOLIS RD, ELICOTT CITY, MD 21042

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

15X1

State  
Registrar

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22051

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Roselyn Catherine Dietrich				2. Date of Death Month Day Year June 28, 2000				3. Time of Death 19:50			
	4a. Facility Name (If not Institution, give street and number) 2225 Grafton Shop Road				4b. City, Town, or Location of Death Forest Hill				4c. County of Death Harford			
Funeral Director	5. Social Security Number 212-03-6177		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) 1/26/1911		9. Birthplace (State or Foreign Country) Maryland			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 5628 A Loch Raven Blvd.				10f. Zip Code 21239		10g. Citizen of What Country? U.S.A.					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) William E. Meeth				18. Mother's Name (First, Middle, Maiden Surname) Rose K. Ries							
	19a. Informant's Name/Relationship (Type, Print) Ronald Dietrich/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3915 Fleetwood Avenue Baltimore, Maryland 21206							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, Cemetery		Date 7/1/00		20c. Location - City or Town, State Baltimore, Maryland					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. ASCVD Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  COPD										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Assisted Living										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
29b. Signature and title of certifier 				29c. License number OCME				29d. Date signed (Month, Day, Year) June 28, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W-J 128 BELAIR RD BALTIMORE MD 21014 410 879 6524												
31. Date filed (Month, Day, Year) JUL 12 2000		32. Registrar's Signature 										

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22052

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Herman G Everett

2. Date of Death

Month  
7Day  
10Year  
00

3. Time of Death

12:32 AM

4a. Facility Name (If not institution, give street and number)

Veterans Affairs Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

242-32-1592

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth (Month, Day, Year)

05-16-29

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2600 Kirk Avenue

10f. Zip Code

21218

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Bethlehem Steel Co.

17. Father's Name (First, Middle, Last)

James

Everett

18. Mother's Name (First, Middle, Maiden Summa)

Elizabeth

Weston

19e. Informant's Name/Relationship (Type, Print)

Eunice Everett

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2600 Kirk Avenue Baltimore, Maryland 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA Cem. 07-14-2000 Owings Mills

Data

20c. Location - City or Town, State MD

21. Signature of Funeral Service Licensee

▶ Gladys Warner

22. Name and Address of Facility

Baltimore, Maryland 21202  
WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Nonsmall cell lung carcinoma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ [Signature]

29c. License number

P12411

29d. Date signed (Month, Day, Year)

July 10th 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeffrey Held 10 W. Green St Baltimore 21261

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22053

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Stuart W. Entwistle

2. Date of Death

Month Day Year  
June 28 2000

3. Time of Death

10:30am

4a. Facility Name (If not institution, give street and number)

Gilchrist Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

215-24-7942

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 26, 1922

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

6013 Hunt Ridge Road

10f. Zip Code

21210

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Environmental

17. Father's Name (First, Middle, Last)

Alfred Entwistle

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Whalley

19a. Informant's Name/Relationship (Type, Print)

Stuart D. Entwistle - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10928 Powers Avenue Cockeysville, MD 21030

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

6/29/00

20c. Location - City or Town, State

Towson, MD

21. Signature of Funeral Service Licensee

Dennis C. Carroll, per DVR

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Road, Towson, MD 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. cardiorespiratory arrest

Approximate Interval Between Onset and Death

3 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. pleural effusion

3 mos

c. lung cancer

2 yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rodney Williams, MD

29c. License number

D39099

29d. Date signed (Month, Day, Year)

6/28/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rodney Williams, MD, GMC, Baltimore MD 21204

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Entwistle, Stuart 6/28/00 @ 10:30 AM



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22054

amend item 26 per phys. G785 7/12/00 yg

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>INEZ LOUISE FULTON</i>		2. Date of Death Month <i>July</i> Day <i>7</i> Year <i>2000</i>		3. Time of Death <i>10:40 AM.</i>
	4e. Facility Name (If not institution, give street and number) <i>Good SAMARITAN HOSPITAL</i>		4b. City, Town, or Location of Death <i>BALTIMORE</i>		4c. County of Death <i>N/A</i>
Funeral Director	5. Social Security Number <i>212-34-1364</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>65</i> Yrs.	If Under 1 Year Months <i>0</i> Days <i>0</i>	If Under 24 Hrs. Hours <i>0</i> Min. <i>0</i>
	8. Date of Birth (Month, Day, Year) <i>1-5-35</i>		9. Birthplace (State or Foreign Country) <i>md.</i>		
Usual Residence of Decedent					
10a. State <i>md.</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>BALTIMORE</i>	
10e. Street and Number <i>2701 Woodside Ave</i>		10f. Zip Code <i>21214</i>		10g. Citizen of What Country? <i>USA</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>1 yr.</i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>HOUSEWIFE</i>		16b. Kind of Business/Industry <i>HOME</i>	
17. Father's Name (First, Middle, Last) <i>UNKNOWN</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>HAZEL TUNN</i>			
19a. Informant's Name/Relationship (Type, Print) <i>SHERNICE FULTON / daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2701 Woodside Ave - Balt., md. 21214</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>BALTIMORE Nat'l Cem</i>		20c. Location - City or Town, State <i>BALTIMORE, md.</i>	
21. Signature of Funeral Service Licensee <i>Funeral Committee</i>		22. Name and Address of Facility <i>BETTS FUNERAL HOME 1129 N. CAROLINE ST. - Balt., MD 21213</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>non Hodgkin's Lymphoma</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>Pulmonary Embolism</i> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		Approximate Interval Between Onset and Death <i>6 months</i>			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Pulmonary Embolism</i>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M <i>1</i> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Dr. J. B. Skelton M.D.</i>		29c. License number <i>D0054911</i>	
29d. Date signed (Month, Day, Year) <i>07-10-00</i>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Rodrigo B. Erlich 4940 Eastern Ave. - Baltimore MD 21224</i>					
31. Date filed (Month, Day, Year) <i>JUL 12 2000</i>		32. Registrar's Signature <i>penner P Sparks</i>			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22055

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Annie Mae Frank</b>		2. Date of Death Month Day Year <b>July 07 2000</b>		3. Time of Death <b>10:17AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Union Memorial Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death
Funeral Director	5. Social Security Number <b>237-52-9240</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>76</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>04 22 24</b>		9. Birthplace (State or Foreign Country) <b>S.C.</b>		
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>1004 West 41th Street</b>		10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>9th grade na</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>City Hospital</b>
	17. Father's Name (First, Middle, Last) <b>Zin Fox</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Tomasina Murray</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Sylvia Seymour-Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>834 Glenwood Ave, Baltimore Md 21212</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Druid Ridge Cemetery</b>		20c. Location - City or Town, State <b>7/13/00 Pikesville, Md</b>
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Ave, Baltimore Md 21215</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>idiopa this interstitial pulmonary fibrosis 4 years</b>				Approximate Interval Between Onset and Death
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
	Due to (or as a consequence of):				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Buthaina Richeh M.D.</b>		29c. License number <b>AT-2438946-R</b>		29d. Date signed (Month, Day, Year) <b>July-07-2000</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Buthaina Richeh M.D., 201 East University Park Way Baltimore Md 21218</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>JUL 12 2000</b>		32. Registrar's Signature <i>[Signature]</i>		







Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 22056

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ernest Donald Gossett				2. Date of Death Month Day Year June 27, 2000		3. Time of Death 2:30 AM	
	4a. Facility Name (If not institution, give street and number) 9548 Quarry Bridge Ct.				4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
Funeral Director	5. Social Security Number 249-80-0784		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 54 Yrs.		8. Date of Birth (Month, Day, Year) Dec. 15, 1945	
	Usual Residence of Decedent		10e. State MD		10b. County Howard		10c. City, Town or Location Columbia	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 9548 Quarry Bridge Ct.		10f. Zip Code 21046		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assembly Worker		16b. Kind of Business/Industry G. E. Appliances				
17. Father's Name (First, Middle, Last) Lawrence Lawson Gossett				18. Mother's Name (First, Middle, Maiden Surname) Madora Dawkins				
19a. Informant's Name/Relationship (Type, Print) Patricia Gossett - wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9548 Quarry Bridge Ct., Columbia, Md. 21046				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Memorial Pk.		Date 7/01/00		20c. Location - City or Town, State Elkridge, Md.		
21. Signature of Funeral Service Licensee Mst. Marshall				22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. END stage carcinoma Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Alcoholism								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Mst. Marshall				29c. License number D0057958		29d. Date signed (Month, Day, Year) 6-30-00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MBOURSQUOT, M-D TWO KNOLL NORTH DRIVE COLUMBIA MD 21045								
31. Date filed (Month, Day, Year) JUL 12 2000				32. Registrar's Signature B. Sparks				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22057

amend item 26 per phys. G785 7/12/00 yg

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Delores C. Gilmore

2. Date of Death

Month Day Year  
July 8, 2000

3. Time of Death

21:00

4a. Facility Name (If not institution, give street and number)

521 Donaldson Avenue

4b. City, Town, or Location of Death

Severn

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

219-16-8610

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hour Min.

8. Date of Birth

(Month, Day, Year)  
9/18/1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

521 Donaldson Avenue

10f. Zip Code

21144

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cafeteria

16b. Kind of Business/Industry

A.A.Co. Public Schools

17. Father's Name (First, Middle, Last)

John Jubb

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Hoffman

19a. Informant's Name/Relationship (Type, Print)

Charlene Gilmore - Daug.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

500-3 Victory Way, Pasadena, MD 21122

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory

Date

7/11/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Kelly Gregory Fink

22. Name and Address of Facility

Fink Funerals Home, PA

426 Crain Hwy., SW, Glen Burnie, MD 21061

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Myocardial Infarction  
Due to (or as a consequence of):Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Coronary artery disease  
Due to (or as a consequence of):c. Hypertension  
Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ Other

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at home

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anil Chopra

29c. License number

D 46816

29d. Date signed (Month, Day, Year)

7/10/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANIL CHOPRA 7575 Ritchie Highway Glen Burnie Md.

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

Anil Chopra

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.  
State of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

00 22058

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Stephen Wayne Griffin</b>				2. Date of Death Month <b>July</b> Day <b>08</b> Year <b>2000</b>				3. Time of Death <b>915 am</b>		
	4a. Facility Name (If not Institution, give street and number) <b>55 Wade Avenue Room 123</b>				4b. City, Town, or Location of Death <b>Catonsville</b>				4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>217-68-1729</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>43</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 7, 1957</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Catonsville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>55 Wade Avenue Rm 123</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U.S.A.</b>					
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Never Worked</b>				16b. Kind of Business/Industry <b>N/A</b>			
17. Father's Name (First, Middle, Last) <b>James Albert Griffin</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Arlene Rose Middleditch</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Yvonne Ryan/Sister</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7109 Greenwood Avenue Baltimore, Maryland 21206</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		20c. Date <b>7/12/00</b>		20d. Location - City or Town, State <b>Baltimore, Maryland</b>				
21. Signature of Funeral Service Licensee <i>[Signature]</i>					22. Name and Address of Facility <b>John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Dilated Cardiomyopathy</b> Due to (or as a consequence of):  Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Schizophrenia</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.										Approximate Interval Between Onset and Death	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown											
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <i>[Signature]</i> <b>M.D.</b>					29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>July 09, 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>JUL 12 2000</b>			32. Registrar's Signature <i>[Signature]</i>								

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar

DHMH 16 Rev 6/95





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #15 PER F.H. G785 7-12-00 WR.

Certificate of Death

Reg. No.

00 22059

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>JACQUELINE V. JONES</b>		2. Date of Death Month <b>JULY</b> Day <b>08</b> Year <b>2000</b>		3. Time of Death <b>1310 hrs</b>	
4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death	
5. Social Security Number <b>213-52-2771</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>51</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>10 28 48</b>		9. Birthplace (State or Foreign Country) <b>M.D.</b>			
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2919 Gwynns Falls Parkway</b>		10f. Zip Code <b>21216</b>	
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>na</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>Social Security Administration</b>		17. Father's Name (First, Middle, Last) <b>James Archie Jones</b>	
18. Mother's Name (First, Middle, Maiden Sumama) <b>Virginia Morton</b>		19a. Informant's Name/Relationship (Type, Print) <b>Curtis Jones-Brother</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1727 Ramblewood Road, Baltimore Md 21239</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		20c. Location - City or Town, State <b>7/13/00 Baltimore Co, Md</b>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>March F/H West</b> <b>4300 Wabash Ave, Baltimore Md 21215</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ACUTE RESPIRATORY SYNDROME</b> Due to (or as a consequence of): <b>SEPTIC SHOCK SYNDROME</b> Due to (or as a consequence of): <b>MULTI ORGAN FAILURE</b> Due to (or as a consequence of):	
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SYSTEMIC LUPUS</b> <b>TYPE II DIABETES</b>		23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23d. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
23e. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		24a. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
25. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		26a. Date of Injury (Month, Day, Year)		26b. Time of Injury <b>M</b>	
26c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		26d. Describe how injury occurred		26e. Location (Street and Number or Rural Route Number, City or Town, State)	
26f. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		26g. Location (Street and Number or Rural Route Number, City or Town, State)		26h. Location (Street and Number or Rural Route Number, City or Town, State)	
26i. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		26j. License number <b>P 13965</b>		26k. Date signed (Month, Day, Year) <b>JULY 08 2000</b>	
26l. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RATNA NAIR GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLVD. BALTIMORE</b>		26m. Date filed (Month, Day, Year) <b>JUL 12 2000</b>		26n. Registrar's Signature <i>[Signature]</i>	

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

AMENDED ITEM #8 PER FH G785 7/12/00 AH

00 22060

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DR. R. DONALD JANDORF				2. Date of Death JULY 9 Day 2000		3. Time of Death 8:20PM		
	4a. Facility Name (If not institution, give street and number) BRIGHTWOOD MERIDIAN NURSING CENTER				4b. City, Town, or Location of Death LUTHERVILLE		4c. County of Death BALTIMORE		
Funeral Director	5. Social Security Number 219-07-0235	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JAN 1 1914		9. Birthplace (State or Foreign Country) MD	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MD	10b. County N/A	10c. City, Town or Location BALTIMORE			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number 7121 PARK HEIGHTS AVE APT. 701			10f. Zip Code 21215		10g. Citizen of What Country? USA			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: ARMY AIR CORP		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PHYSICIAN			16b. Kind of Business/Industry MEDICAL			
	17. Father's Name (First, Middle, Last) HENRY R. JANDORF			18. Mother's Name (First, Middle, Maiden Surname) RENA STRAUSS					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) ELLEN JANDORF/WIFE			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7121 PARK HEIGHTS AVE APT. 701 BALTIMORE, MD. 21215					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) BALTIMORE HEBREW		Date 7/11/00		20c. Location - City or Town, State REISTERSTOWN, MD.		
	21. Signature of Funeral Service Licensee			22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208					
	23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. Pneumonia Due to (or as a consequence of): b. Parkinson's disease Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier		29c. License number S 30339		29d. Date signed (Month, Day, Year) 7/10/00					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NILAN WINTER, MD 4000 Old Court Rd. Baltimore, MD 21208									
31. Date filed (Month, Day, Year) JUL 12 2000		32. Registrar's Signature B Sparks							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-555-5555.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22061

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ruth Catherine Killmayer</b>				2. Date of Death Month Day Year <b>July 1, 2000</b>		3. Time of Death <b>2:25 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Levindale Hebrew Geriatric Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>013-20-4918</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>89</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>06/2/1911</b>	
	9. Birthplace (State or Foreign Country) <b>Baltimore</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Woodlawn</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2111 Park Place</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>Unknown</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>		19a. Informant's Name/Relationship (Type, Print) <b>Charles Killmayer/ Son</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2111 Park Place Woodlawn, Maryland 21207</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lorraine Park Cemetery</b>		20c. Date <b>7/3/00</b>		20d. Location - City or Town, State <b>Baltimore, Maryland</b>		21. Signature of Funeral Service Licensee <b>Michele N. Vekula</b>		
22. Name and Address of Facility <b>Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>METASTATIC LUNG CANCER</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Tasneem Lakham</b>		
29c. License number <b>D 28595</b>		29d. Date signed (Month, Day, Year) <b>JULY 1, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TASNEEM LAKHAM, 7220 PARK HEIGHTS AVE, BALD MD</b>		31. Date filed (Month, Day, Year) <b>JUL 12 2000</b>		
32. Registrar's Signature <b>[Signature]</b>		33. Registrar's Title <b>[Signature]</b>		34. Registrar's Name <b>[Signature]</b>		35. Registrar's Address <b>[Signature]</b>		

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

AMEND/17&amp;19b PER INFMT. G785 7-20-2000 JAB

Certificate of Death

Reg. No.

00 22062

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward G. Kyne

2. Date of Death

Jul 8 2000

3. Time of Death

2230

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Howard County Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

215-09-9517

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83

8. Date of Birth (Month, Day, Year)

Aug. 14, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Catonsville

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

615 Hilltop Road

10f. Zip Code

21228

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Postal Work

16b. Kind of Business/Industry

US Postal Service

17. Father's Name (First, Middle, Last)

Edward James Kyne

EDWARD J. KYNE

18. Mother's Name (First, Middle, Maiden Surname)

Sadie Martin

19a. Informant's Name/Relationship (Type, Print)

Jim Kyne/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18 SPARROW HILL CT.  
165 Hilltop Road, Catonsville, Maryland 21228

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

7/12/2000

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Theresa L. Lemmer

M00741

22. Name and Address of Facility

Witzke Funeral Homes, Inc.

1630 Edmondson Avenue, Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

renal failure

degenerating

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Gary H. Sparks

29c. License number

041817

29d. Date signed (Month, Day, Year)

Jul 9, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gary H. Sparks 10805 Hickory Ridge Rd Glenview, MD

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

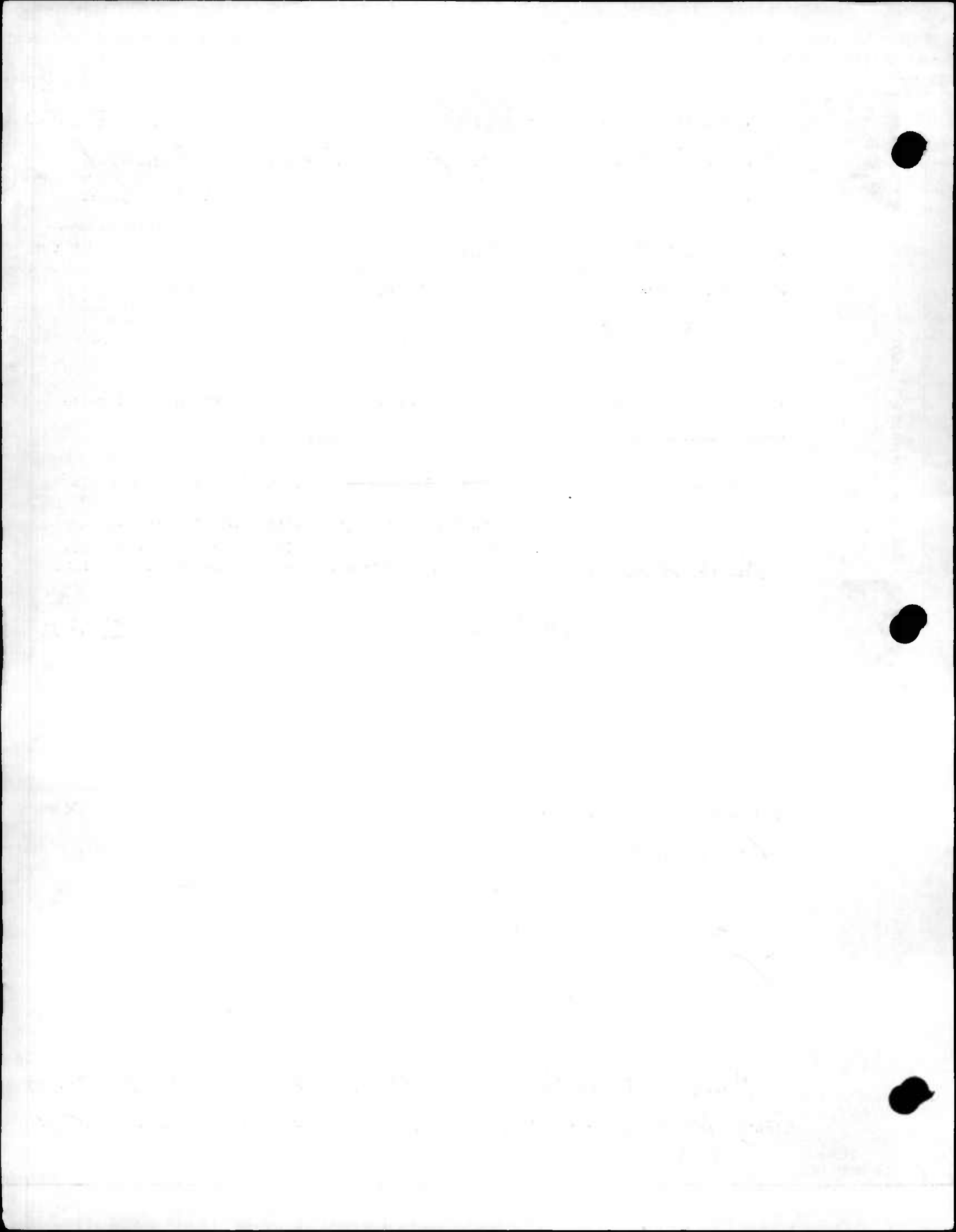
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22063

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOSEPH F. KAPINOS

2. Date of Death

Month 7 Day 4 Year 2000

3. Time of Death

10 PM

4a. Facility Name (If not institution, give street and number)

5600 Knell Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-10-5240

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year) 3-17-18

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5600 Knell Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)  
Elementary/Secondary (0-12) 8  
College (1-4or 5+)16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Letter Carrier

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Frank Joseph Kapinos

18. Mother's Name (First, Middle, Maiden Surname)

Anna (Unknown)

19a. Informant's Name/Relationship (Type, Print)

Claire Kapinos/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5600 Knell Avenue Baltimore, Maryland 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gardens of Faith Cemetery 7/8/00

Date

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

John C. Miller Inc.  
6415 Belair Road Baltimore, Maryland 2120623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. MYELODYSPLASTIC SYNDROME

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 YEAR

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Conrad May MD

29c. License number

D32186

29d. Date signed (Month, Day, Year)

7-7-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CONRAD MAY MD, BALTIMORE VAMC, 10 N GREENE ST., BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
card.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 22064

Physician  
/Medical  
Examiner

Funeral  
Director

Baltimore, Maryland 21215-0020

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

State  
Registrar

1. Decedent's Name (First, Middle, Last) <b>MICHAEL</b>		2. Date of Death Month <b>July</b> Day <b>11</b> Year <b>2000</b>		3. Time of Death <b>11:45pm</b>	
4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>	
5. Social Security Number <b>N/A</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>32</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Aug 11, 1967</b>
Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>AFRICA</b>			
10a. State <b>Greece</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>ITALYSON</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>15 IRAKLIOU KRITIS Street</b>		10f. Zip Code <b>85100</b>		10g. Citizen of What Country? <b>Greece</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ENGINEER</b>	
16b. Kind of Business/Industry <b>ENGINEER</b>		17. Father's Name (First, Middle, Last) <b>KONSTANTINOS</b>		18. Mother's Name (First, Middle, Maiden Summe) <b>LIAMIS ELENI TZORTZI</b>	
19a. Informant's Name/Relationship (Type, Print) <b>PELAGIA LIAMIS - WIFE</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15 IRAKLIOU KRITIS Street Rhodes, Greece 85100</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>TAXIARCHIS, NECROTAFON</b>		20c. Location - City or Town, State <b>Rhodes, Greece</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>JOSEPH N. ZANNINO JR. FUNERAL HOME 263 SOUTH CONKING STREET BALTO. MD 21224</b>			
23a. Patient. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>LIVER FAILURE</b>					Approximate Interval Between Onset and Death <b>2 DAYS</b>
Due to (or as a consequence of): <b>metastatic Endocrine Tumor</b>					<b>2 DAYS</b>
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier MEDICAL RESIDENT		29c. License number <b>P9040</b>		29d. Date signed (Month, Day, Year) <b>JULY 12 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RICHARD OFFER ADDO, 600 N. WOLFE ST. BALTIMORE, MD 21287</b>					
31. Date filed (Month, Day, Year) <b>JUL 18 2000</b>		32. Registrar's Signature 			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22065

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

E. GOLDYE LEVIN

2. Date of Death

JULY 9 2000

3. Time of Death

6AM

4a. Facility Name (If not institution, give street and number)

5714 CARROLL DALE ROAD

4b. City, Town, or Location of Death

SYKESVILLE

4c. County of Death

CARROLL

Funeral  
Director

5. Social Security Number

212-01-6523

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 27 1910

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

CARROLL

10c. City, Town or Location

SYKESVILLE

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

5714 CARROLL DALE ROAD

10f. Zip Code

21784

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

HARRY

TOKAR

18. Mother's Name (First, Middle, Maiden Surname)

VERA

SHANE

19a. Informant's Name/Relationship (Type, Print)

SUSAN C. GOLDSTEIN/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5714 CARROLL DALE ROAD SYKESVILLE, MD. 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

B'NAI ISRAEL CONGREGATION 7/10/00

Date

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS. INC.

8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richmond P. Allan, 1645 Liberty Rd., Eldersburg, MD 21784

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

B Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended Item#3 perPhyG785 7/12/2000 EW

## Certificate of Death

Reg. No.

00 22066

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sophia Anna Litz

2. Date of Death

Month  
June

Day

26

Year

2000

3. Time of Death

5:00 PM

4a. Facility Name (If not institution, give street and number)

308 Orchard Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

213 18 7675

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
April 9, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

308 Orchard Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

St. John School

17. Father's Name (First, Middle, Last)

Conrad Graef

18. Mother's Name (First, Middle, Maiden Surname)

Maggie Durm

19a. Informant's Name/Relationship (Type, Print)

Geraldine Mooney / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

308 Orchard Avenue Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadowridge Memorial Park 6/29/00 Baltimore, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*Donna M. Zimarski*

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Phu MD*

29c. License number

D53462

29d. Date signed (Month, Day, Year)

6/28/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jude Muneses, MD 7845 Oakwood Road.

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

*Benita G. Sparks*

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEM: #26 PER PHY G785 7-12-00 WR. V

Certificate of Death

Reg. No.

00 22067

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Floyd Majette</b>		2. Date of Death Month <b>July</b> Day <b>09</b> Year <b>2000</b>		3. Time of Death <b>15:05</b>
4a. Facility Name (If not institution, give street and number) <b>1507 Homestead Street</b>		4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>
5. Social Security Number <b>240-54-1228</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>02-27-36</b>	9. Birthplace (State or Foreign Country) <b>NC</b>
Usual Residence of Decedent				
10a. State <b>MD</b>	10b. County <b>NA</b>	10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>1507 Homestead Street</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>NA</b>		
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home improvement</b>		16b. Kind of Business/Industry <b>self-employed</b>		
17. Father's Name (First, Middle, Last) <b>Floyd J. Majette, Sr.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Harrison</b>		
19a. Informant's Name/Relationship (Type, Print) <b>Sheryl D. Corry</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1507 Homestead Street Baltimore, Maryland 21218</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest VA Cem. 07-14-2000 Owings Mills</b>		20c. Location - City or Town, State <b>MD.</b>
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Baltimore, Maryland 21202, WM.C. March FH 1101 E. North Avenue</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>CARDIAC FAILURE / MI</b>  Due to (or as a consequence of): <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>  Due to (or as a consequence of): <b>DIABETES MELLITUS TYPE 2</b>  Due to (or as a consequence of): <b>MORBID OBESITY</b>				Approximate Interval Between Onset and Death <b>YEARS 1990 MINUTES</b>
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>LIPIDEMIA</b> <b>ADENOCARCINOMA / RECTUM T3N1M0</b> <b>OSTEOARTHRITIS</b>				23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> Outpatient Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D16333</b>
29d. Date signed (Month, Day, Year) <b>07-10-2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ERNESTO MOLINA, JR. 3450 ELLICOTT C.D.R. SUITE 105 - ELLICOTT CITY - MD 21043</b>		
31. Date filed (Month, Day, Year) <b>JUL 12 2000</b>		32. Registrar's Signature 		

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22068

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Herbert G. McDonald

2. Date of Death

Month Day Year  
July 4, 2000

3. Time of Death

19:01

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

156-32-6290

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 21, 1942

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4141 Henhawk Court

10f. Zip Code

21042

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Puerto Rican

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Baltimore Mack

17. Father's Name (First, Middle, Last)

Herbert G. McDonald, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Malave

19a. Informant's Name/Relationship (Type, Print)

Debbie McDonald/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4141 Henhawk Court, Ellicott City, Maryland 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. John's Cemetery

Date

7/10/00

20c. Location - City or Town, State

Ellicott City, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Witzke Funeral Homes, Inc.  
1630 Edmondson Avenue, Catonsville, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Dilated cardiomyopathy  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

26a. Date of Injury (Month, Day Year)

26b. Time of Injury

M

26c. Injury at Work?

1 ☐ Yes 2 ☐ No

26d. Describe how injury occurred

26e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

26f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D0055437

29d. Date signed (Month, Day, Year)

July 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elizabeth Bower MD 3400 Ellicott Center Drive #103 Ellicott City, MD 21043

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

Geneva B Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 26a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

00 22069

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GENOA MORSE</b>				2. Date of Death Month Day Year <b>JULY 09, 2000</b>				3. Time of Death <b>3:52pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL OF BALTIMORE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>579-24-0147</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>03-08-20</b>		9. Birthplace (State or Foreign Country) <b>VIRGINIA</b>	
	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
To Be Completed by Funeral Director	10e. Street and Number <b>4617 TALMAN ROAD</b>				10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>			
To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TELLER</b>				16b. Kind of Business/Industry <b>COMMUNICATIONS</b>	
	17. Father's Name (First, Middle, Last) <b>ANDREW MORSE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>SALLIE HUDSON</b>					
To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print) <b>GWEN E. MORSE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4617 TALMAN RD, BALTIMORE, MD 21208</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>WOODLAWN CEMETERY</b>		20c. Location - City or Town, State <b>7-14-00 WOODLAWN, MD</b>					
To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HOWELL FUNERAL HOME 4600 LIBERTY HIGHTS AVE, BALTO. MD 21207</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Aspiration Pneumonitis</b> Due to (or as a consequence of): b. <b>Cerebral Vascular Accident</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>P12304</b>		29d. Date signed (Month, Day, Year) <b>July 9 2000</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kathryn G. Barnard, MD Sinai Hospital of Baltimore</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>JUL 12 2000</b>		32. Registrar's Signature 							





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22070

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Betty

Meyerowitz

2. Date of Death

Month

Day

Year

July 7 2000

3. Time of Death

11:30 pm

4a. Facility Name (If not institution, give street and number)

1 Gristmill Court

Apartment 407

4b. City, Town, or Location of Death

Pikesville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

064-07-0009

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

NOV 2 1918

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

1 GRISTMILL COURT APT. 407

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MERCHANT

16b. Kind of Business/Industry

RETAIL

17. Father's Name (First, Middle, Last)

CHARLES

18. Mother's Name (First, Middle, Maiden Surname)

SEROTA

18. Mother's Name (First, Middle, Maiden Surname)

HANNAH

18. Mother's Name (First, Middle, Maiden Surname)

BIER

19a. Informant's Name/Relationship (Type, Print)

PEGGY MEYEROWITZ/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

46 STIRRUP COURT BALTIMORE, MD. 21208

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE HEBREW

Date

7/10/00

20c. Location - City or Town, State

REISTERSTOWN, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS. INC.

8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dementia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Neurodegenerative Disorder

Due to (or as a consequence of):

4 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

July 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Monica Srodon, MD 600 North Wolfe Street Baltimore, Maryland 21287

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22071

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Albert William Meyers				2. Date of Death Month JULY Day 8, Year 2000				3. Time of Death 1947 PM						
	4a. Facility Name (If not institution, give street and number) 33 N. KRESSON STREET				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death						
Funeral Director	5. Social Security Number 213-14-5095		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 77 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) 12/25/1922		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent														
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore						10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 33 N. Kresson Street				10f. Zip Code 21224				10g. Citizen of What Country? U.S.A.							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machinist				16b. Kind of Business/Industry Manufacturing							
17. Father's Name (First, Middle, Last) William Meyers				18. Mother's Name (First, Middle, Maiden Surname) Eva Connor											
19a. Informant's Name/Relationship (Type, Print) Ronald Meyers/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13206 Patuxent Road Chase, Maryland 21220											
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Oaklawn Cemetery				Date 7/13/00		20c. Location - City or Town, State Baltimore, Maryland					
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Dinner Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206											
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>Gunshot Wound OF HEAD</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last												Approximate Interval Between Onset and Death		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown												24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE											
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year) 7/8/00		28b. Time of Injury 1930		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred Subject Shot					
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) House				28f. Location (Street and Number or Rural Route Number, City or Town, State) 33 N. Kresson St. Baltimore, Md.											
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>[Signature]</i> MD				29c. License number OCME				29d. Date signed (Month, Day, Year) JULY 9, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) JUL 12 2000				32. Registrar's Signature <i>[Signature]</i>											

ORIGINAL

Chad - 2 hours 1. Trip

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State of Maryland / Department of Health and Mental Hygiene 00 22072

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Phillip Jeffrey Meyers				2. Date of Death Month Day Year JULY 8, 2000				3. Time of Death 1947 PM					
	4a. Facility Name (If not Institution, give street and number) 33 N. KRESSON STREET				4b. City, Town, or Location of Death BALTIMORE CITY				4c. County of Death					
Funeral Director	5. Social Security Number 219-82-6279		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 42 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) 11/18/1957		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent													
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore						10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				
10e. Street and Number 33 N. Kresson Street				10f. Zip Code 21224				10g. Citizen of What Country? U.S.A.						
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: White				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electronics				16b. Kind of Business/Industry Self Employed						
17. Father's Name (First, Middle, Last) Albert William Meyers						18. Mother's Name (First, Middle, Maiden Surname) Josephine Jakuboski								
19a. Informant's Name/Relationship (Type, Print) Ronald Meyers/Brother						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13206 Patuxent Road Chase, Maryland 21220								
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Oaklawn Cemetery				Date 7/13/00		20c. Location - City or Town, State Baltimore, Maryland				
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206										
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <i>Contact Gunshot Wound of Head</i> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.										Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No								
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DGA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE										
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year) 7/8/00		28b. Time of Injury (Hour, Min) 1930		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <i>Subject Shot Self</i>				
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <i>House</i>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <i>33 N. Kresson St. Baltimore, Md.</i>										
29e. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier <i>[Signature]</i> M.D.				29c. License number OCME				29d. Date signed (Month, Day, Year) JULY 9, 2000						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</i>														
31. Date filed (Month, Day, Year) JUL 12 2000				32. Registrar's Signature <i>[Signature]</i>										

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22073

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) <b>JOCE ANN NURSE</b>				2. Date of Death Month <b>07</b> Day <b>05</b> Year <b>2000</b>		3. Time of Death <b>15:14</b>	
4a. Facility Name (If not institution, give street and number) <b>Holy Cross Hospital</b>				4b. City, Town, or Location of Death <b>Silver Spring</b>		4c. County of Death <b>Montgomery</b>	
5. Social Security Number <b>150-34-5712</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>64</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>06-04-36</b>	
9. Birthplace (State or Foreign Country) <b>Indiana</b>							
Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Silver Springs</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>2122 Randolph Road</b>				10f. Zip Code <b>20902</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Music, Math + Science Supervisor</b>		16b. Kind of Business/Industry <b>D.C. - Education System</b>	
17. Father's Name (First, Middle, Last) <b>Gordon Willis, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Katherine Brodie</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Walter Green / Friend</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2122 Randolph Road, Silver Springs, MD 20902</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenwood Cemetery</b>		Date <b>7/13/2000</b>		20c. Location - City or Town, State <b>Atlantic City, NJ</b>	
21. Signature of Funeral Service Licensee <b>[Signature]</b>				22. Name and Address of Facility <b>Harri P. Close Funeral Service, P. A. 709 Tessler Street, Balt., MD 21201-1924</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Myocardial Infarction</b> Due to (or as a consequence of): <b>b. Congestive Cardiomyopathy</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Approximate Interval Between Onset and Death <b>(Unknown)</b>							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension Diabetes</b> <b>Chronic Obstructive Pulmonary Disease</b>							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier <b>[Signature] Paul B. Johnson MD</b>				29c. License number <b>035112</b>		29d. Date signed (Month, Day, Year) <b>7/05/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Holy Cross Hospital Silver Spring MD</b>							
31. Date filed (Month, Day, Year) <b>JUL 12 2000</b>				32. Registrar's Signature <b>[Signature] B. Sparks</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22074

Amend Item 25 per ME,dhb 7/12/00 G785

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Harry Joseph Patton</b>				2. Date of Death Month <b>July</b> Day <b>6</b> Year <b>2000</b>		3. Time of Death <b>5:15 a.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Broadmead</b>				4b. City, Town, or Location of Death <b>Cockeysville</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>272-10-2906</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>85</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>March 7, 1915</b>		9. Birthplace (State or Foreign Country) <b>Ohio</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Cockeysville</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>13801 York Road</b>				10f. Zip Code <b>21030</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>photographer</b>			16b. Kind of Business/Industry <b>museum</b>	
17. Father's Name (First, Middle, Last) <b>Dennis Patton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lesta Correne Davis</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Broadmead</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13801 York Road Cockeysville, MD 21030</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>ESOPHAGEAL CANCER</b> Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):								Approximate Interval Between Onset and Death <b>7 yr</b>
23b. Immediate Cause (Final disease or condition resulting in death)								
23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ischemic Heart Disease</b> <b>Waldenström's Macroglobulinemia</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Barbara Carroll, MD</b>				29c. License number <b>D38392</b>		29d. Date signed (Month, Day, Year) <b>7/6/2000</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>BARBARA CARROLL, MD, 13801 YORK RD., COCKEYSVILLE</b>								
31. Date filed (Month, Day, Year) <b>JUL 12 2000</b>				32. Registrar's Signature <b>Benjamin B. Sparks</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22075

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ZOLMAN

RIMSON

2. Date of Death

Month

Day

Year

3. Time of Death

July 8 2000 0120

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

SINAI HOSPITAL OF BALTIMORE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-12-4019

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

JAN. 1 1920

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☐ Yes ☒ No

10a. Street and Number

10 MONTAIGNE COURT APT. 2-B

10f. Zip Code

21208

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☒ Yes ☐ No

Year of Dates:

WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MECHANIC

16b. Kind of Business/Industry

AUTOMOBILE

17. Father's Name (First, Middle, Last)

ABRAHAM

RIMSON

18. Mother's Name (First, Middle, Maiden Surname)

BELLA

LUNTZ

19a. Informant's Name/Relationship (Type, Print)

LILLIAN STICHMAN/SISTER-IN-LAW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 MONTAIGNE COURT APT. 2-A BALTIMORE, MD. 21208

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ADATH YESHURUN

Date

7/10/00

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

SOL LEVINSON &amp; BROS. INC.

8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOGENIC SHOCK

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ACUTE MI

Due to (or as a consequence of):

4 DAYS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RESPIR. DISTRESS SYNDROME

ACUTE RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24e. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined☐ Could not be determined☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury et Work?

☐ Yes ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

July 8 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERROL K KOLEN

SINAI HOSPITAL OF BALTIMORE

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

[Signature]

State  
Registrar

PT KNOWN AS RIMSON ZOLMAN

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

AN



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22076

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) ANNA RIBERKOF				2. Date of Death Month Day Year JULY 10 2000		3. Time of Death 5:40AM
	4a. Facility Name (If not institution, give street and number) MILFORD MANOR NURSING HOME				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death BALTIMORE
Funeral Director	5. Social Security Number 216-36-7793	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12/27/1909	9. Birthplace (State or Foreign) MD.
	Usual Residence of Decedent						
To Be Completed by Funeral Director	10a. State MD	10b. County BALTIMORE	10c. City, Town or Location BALTIMORE		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 6634 SANZO ROAD #A			10f. Zip Code 21209		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (14 or 5+)		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) CASHIER		16b. Kind of Business/Industry GROCERY STORE		
	17. Father's Name (First, Middle, Last) ISRAEL FRIEDMAN				18. Mother's Name (First, Middle, Maiden Surname) IDA GOLDINER		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) SHEILA HYATT/DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 VALLEY GATE WAY BALTIMORE, MD. 21208		
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) B'NAI JACOB CONGREGATION		Date 7/11/00	20c. Location - City or Town, State BALTIMORE, MD.	
	21. Signature of Funeral Service Licensee <i>Michael Brown</i>				22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208		
	23a. Part I. Enter the disease, or complications, which caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one condition on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Critical Aortic Stenosis</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Severe chronic obstructive pulmonary disease (related to cigarette use)</u>						
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown						
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
State Registrar	29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	29b. Signature and title of certifier <i>D Roggen</i>		29c. License number D35844		29d. Date signed (Month, Day, Year) July 10, 2000		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>D Roggen</i> 5400 Old Court Road Randallstown MD 21133						
31. Date filed (Month, Day, Year) JUL 12 2000		32. Registrar's Signature <i>B Sparks</i>					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22077

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LOUIS SORRELL				2. Date of Death Month Day Year July 09 2000				3. Time of Death 8:15 AM													
	4a. Facility Name (If not institution, give street and number) St Agnes Hospital				4b. City, Town, or Location of Death Baltimore				4c. County of Death N/A													
Funeral Director	5. Social Security Number 216-22-3191		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 40 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 10, 1929		9. Birthplace (State or Foreign Country) MARYLAND													
	Usual Residence of Decedent																					
To Be Completed by Funeral Director	10a. State MD.		10b. County N/A		10c. City, Town or Location BALTIMORE				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
	10e. Street and Number 5700 RADECKE AVE APT. B1				10f. Zip Code 21206		10g. Citizen of What Country? U.S.A.															
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK														
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) N/A				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) STOCK WORKER			16b. Kind of Business/Industry BAKING INDUSTRY														
	17. Father's Name (First, Middle, Last) JOHN SORRELL				18. Mother's Name (First, Middle, Maiden Surname) BERTHA WOODS																	
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) SHEILA MAYO- DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5700 RADECKE AVE. BALTO, MD. 21206 APT. B1																	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) MOUNT ZION CEMETERY 7/18/00 LANSDOWNE, MARYLAND				20c. Location - City or Town, State													
	21. Signature of Funeral Service Licensee Lewis T. Gwynn				22. Name and Address of Facility LEWIS T. GWYNN FUNERAL HOME 4517 PARKHEIGHTS AVE. BALTIMORE, MD. 21215																	
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																					
	23b. Approximate Interval Between Onset and Death																					
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>Myocardial Infarction</td> <td>12 hours</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of): Metastatic Liver Cancer</td> <td>&gt; 2 yrs</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	Myocardial Infarction	12 hours	b.	Due to (or as a consequence of): Metastatic Liver Cancer	> 2 yrs	c.	Due to (or as a consequence of):		d.	Due to (or as a consequence of):	
Immediate Cause (Final disease or condition resulting in death)	a.	Myocardial Infarction	12 hours																			
	b.	Due to (or as a consequence of): Metastatic Liver Cancer	> 2 yrs																			
	c.	Due to (or as a consequence of):																				
	d.	Due to (or as a consequence of):																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
								24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																						
29b. Signature and title of certifier [Signature] MD				29c. License number P36597				29d. Date signed (Month, Day, Year) July 09 2000														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin's Ugwu-Dike, MD 900 Caton Ave Baltimore MD 21236																						
31. Date filed (Month, Day, Year) JUL 12 2000				32. Registrar's Signature [Signature]																		

ORIGINAL

July 21-2

July 21-2

July 21-2

July 21-2

CHRISTOPHER  
SPENCER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22078

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHRISTOPHER SPENCER

2. Date of Death

Month Year  
JULY 8, 2000

3. Time of Death

3:36P.M.

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-94-6674

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

20 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN. 24, 1980

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4169 FAIRVIEW AVE.

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12thCollege (1-4 or 5+)  
N/A16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

UNEMPLOYED

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

JAMES EZELL SPENCER

18. Mother's Name (First, Middle, Maiden Surname)

AMANDA DARLENE JONES

19a. Informant's Name/Relationship (Type, Print)

ERNESTINE JONES-GRANDMOTHER

4169 FAIRVIEW AVE. BALTO. MD. 21216

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

DRUID RIDGE CEMETERY 7/15/00 PIKESVILLE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Lewis T. Gwynn

22. Name and Address of Facility

LEWIS T. GWYNN FUNERAL HOME

4517 PARKHEIGHTS AVE. BALTO. MD. 21215-6393

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Methylenes Purple Shot Wounds*  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☒ Yes ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☒ Yes ☐ No25. Was case referred to medical  
examiner?  
☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☒ Homicide

28a. Date of Injury

(Month, Day, Year)  
7/18/0028b. Time of  
Injury

5pm M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

Subject Shot

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)  
street28f. Location (Street and Number or Rural Route Number,  
City or Town, State)  
3020 Wolcott  
Avenue Baltimore Maryland29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 9, 2000

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

THEODORE M. KING

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

Beverly B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
0028.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22079

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>Ella Swinton</b>				2. Date of Death Month <b>July</b> Day <b>4</b> Year <b>2000</b>		3. Time of Death <b>5:30 P</b>	
4a. Facility Name (If not institution, give street and number) <b>Mariner Health Care of Overlea</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
5. Social Security Number <b>088-28-3151</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>09-07-07</b>	9. Birthplace (State or Foreign Country) <b>SC</b>

Funeral  
Director

To Be Completed by Funeral Director

Usual Residence of Decedent		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number <b>6116 Belair Road</b>				10f. Zip Code <b>21206</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3rd. Grade</b> College (1-4 or 5+) <b>NA</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housekeeping</b>			16b. Kind of Business/Industry <b>Company</b>			
17. Father's Name (First, Middle, Last) <b>Jeff Swinton</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lula Thompson</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Rev. Clavon Burston</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1216 Woodbourne Avenue Baltimore, MD. 21239</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Pk. Cem. 07-13-2000 Randallstown, MD</b>		Date		20c. Location - City or Town, State			
21. Signature of Funeral Service Licensee <b>Lady Wauer</b>				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C. March FH 1101 E. North Avenue</b>					

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death	
a. <b>Bacterial Sepsis</b> Due to (or as a consequence of):		<b>&gt; 2 Wks</b>	
b. <b>Chronic Renal failure</b> Due to (or as a consequence of):		<b>&gt; 1 yr</b>	
c. Due to (or as a consequence of):			
d. Due to (or as a consequence of):			

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					

29b. Signature and title of certifier  
**Khan MD**

29c. License number  
**D25391**

29d. Date signed (Month, Day, Year)  
**7-7-2000**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
**5601- Loch Raven Blvd, Baltimore MD 21239**

State  
Registrar

31. Date filed (Month, Day, Year)  
**JUL 12 2000**

32. Registrar's Signature  
**Anna B Sparks**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

LULA SWINTON





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22080

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Harry Sessa

2. Date of Death

Month Day Year  
July 5 2000

3. Time of Death

5<sup>00</sup> AM

4a. Facility Name (If not institution, give street and number)

1807 Ramsay Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

212-03-8250

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec 01, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1807 Ramsay Street

10f. Zip Code

21223

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11College (1-4 or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Bakery Distributor

17. Father's Name (First, Middle, Last)

Rosario Sessa

18. Mother's Name (First, Middle, Maiden Surname)

Anna Maggerson

19a. Informant's Name/Relationship (Type, Print)

Leonard A. Sessa / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12107 Mayapple Trail, Mariottsville, MD 21104

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dulaney Valley Cemetery

Date

7/8/2000

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

Ann Y. Zink

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

COPD

a.

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

years

b.

Tobacco Abuse

Due to (or as a consequence of):

years

c.

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carotid Stenosis

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Thomas Ghiorzi

29c. License number

051811

29d. Date signed (Month, Day, Year)

July 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Ghiorzi 1120 N. Rolling Rd Balt MD 21228

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-624-2024.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22081

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Iva Nell Sherman				2. Date of Death Month Day Year July 9, 2000				3. Time of Death 10:45 pm		
	4e. Facility Name (If not institution, give street and number) 1037 Marton Street				4b. City, Town, or Location of Death Laurel				4c. County of Death Prince George		
Funeral Director	5. Social Security Number 215-40-7161		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 59 Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		
	8. Date of Birth (Month, Day, Year) May 4, 1941		9. Birthplace (State or Foreign Country) Tennessee		Usual Residence of Decedent						
10a. State MD		10b. County Prince George		10c. City, Town or Location Laurel		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
10e. Street and Number 1037 Marton Street		10f. Zip Code 20707		10g. Citizen of What Country? USA							
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8		College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Cashier		16b. Kind of Business/Industry Retail					
17. Father's Name (First, Middle, Last) Frank Hickman				18. Mother's Name (First, Middle, Maiden Surname) Lutcia Barrette							
19a. Informant's Name/Relationship (Type, Print) Eric Sherman/Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1037 Marton Street, Laurel, Maryland 20707							
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		Date 7/13/00		20c. Location - City or Town, State Elkridge, Maryland					
21. Signature of Funeral Service Licensee Shonda L Lemmer				22. Name and Address of Facility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		e. Small Cell Lung Carcinoma Due to (or as a consequence of):				Approximate Interval Between Onset and Death 27 Months					
b. Due to (or as a consequence of):		c. Due to (or as a consequence of):				d. Due to (or as a consequence of):					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Registrar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Thomas A. Bensinger MD		29c. License number D08754		29d. Date signed (Month, Day, Year) July 11, 2000					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas A. Bensinger, M.D., 7525 Greenway Gr. Dr., Greenbelt, MD						31. Date filed (Month, Day, Year) JUL 12 2000		32. Registrar's Signature Benita B. Sparks			

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 22082

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES TAYLOR</b>				2. Date of Death Month Day Year <b>JULY 9 2000</b>		3. Time of Death <b>01:10AM</b>							
	4a. Facility Name (If not institution, give street and number) <b>BAYVIEW MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>							
Funeral Director	5. Social Security Number <b>216-86-3095</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>36</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>02-03-64</b>							
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>							
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1534 Abbotston Street</b>		10f. Zip Code <b>21218</b>								
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:								
14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High Sch. Grad</b> College (1-4or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Maintenance</b>		16b. Kind of Business/Industry <b>Company</b>								
17. Father's Name (First, Middle, Last) <b>Joseph S. Gray</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Delores Taylor</b>										
19a. Informant's Name/Relationship (Type, Print) <b>Delores Cook</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1534 Abbotston Street Baltimore, MD. 21218</b>										
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell Mem. Gardens</b>		20c. Location - City or Town, State <b>07-13-2000 Dundalk, MD</b>		20d. Date								
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>PNEUMONIA</b></td> <td rowspan="4">           Due to (or as a consequence of):             Due to (or as a consequence of):             Due to (or as a consequence of):             Due to (or as a consequence of):         </td> <td rowspan="4">           Approximate Interval Between Onset and Death   <b>4 days</b>   <b>10 years</b> </td> </tr> <tr> <td>b. <b>AIDS</b></td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>PNEUMONIA</b>	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>4 days</b>  <b>10 years</b>	b. <b>AIDS</b>	c.	d.
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. <b>PNEUMONIA</b>	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	Approximate Interval Between Onset and Death  <b>4 days</b>  <b>10 years</b>											
	b. <b>AIDS</b>													
	c.													
	d.													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No								
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier  MD				29c. License number <b>KES-060</b>		29d. Date signed (Month, Day, Year) <b>JULY 9, 2000</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AUDREY LIU</b>				31. Date filed (Month, Day, Year) <b>JUL 12 2000</b>										
32. Registrar's Signature 														

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22083

AMENDED ITEM #5 PER FH G785 7/12/00 AH

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLES THIMAN</b>				2. Date of Death Month Day Year <b>JULY 8<sup>th</sup> 2000</b>		3. Time of Death <b>18:00</b>	
	4a. Facility Name (If not institution, give street and number) <b>LEVINDALE HEBREW HOME</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>215-03-1815 A</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>97</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAY 6 1903</b>	
	9. Birthplace (State or Foreign Country) <b>MD.</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3307 GLEN AVENUE</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALESMAN</b>		16b. Kind of Business/Industry <b>CLOTHING</b>			
	17. Father's Name (First, Middle, Last) <b>JACOB THIMAN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>REBECCA (UNKNOWN)</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>RHEA B. SNYDER/ NIECE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16 WAINWRIGHT DRIVE ANNAPOLIS, MD. 21401</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MOGAN ABRAHAM CONGREGATION</b>		Date <b>7/11/00</b>		20c. Location - City or Town, State <b>ROSEDALE, MD.</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>END STAGE DEMENTIA</b> Due to (or as a consequence of):  b. <b>DEPRESSION</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>2 YEARS</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Donna M. Ewenley M.D.</b>		29c. License number <b>D0054739</b>		29d. Date signed (Month, Day, Year) <b>JULY 9<sup>th</sup> 2000</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>2434 W. Belvedere Avenue, Baltimore Maryland 21215</b>							
	31. Date filed (Month, Day, Year) <b>JUL 12 2000</b>				32. Registrar's Signature 			





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22084

Amended Item#25,27,28a-f perPhyG785 7/7/2000 EW

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LEROY

THOMAS SR.

2. Date of Death

JUNE

17

2000

3. Time of Death

8:25 AM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-30-7805

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

APRIL 12, 1936

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3009 MANHATTAN AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2 YRS

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

POLICE OFFICER

16b. Kind of Business/Industry

BALTO CITY POLICE DEPT.

17. Father's Name (First, Middle, Last)

FRANCIS LEROY THOMAS

18. Mother's Name (First, Middle, Maiden Surname)

CLARA UNDERWOOD

19a. Informant's Name/Relationship (Type, Print)

LEROY THOMAS (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3009 MANHATTAN AVE. BALTO. MD. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

DRUID RIDGE CEMETERY 6-22-00 PIKESVILLE, MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph H. Brown Jr.

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME  
2140 N. FULTON AVE. BALTIMORE, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. RENAL FAILURE - ACUTE ON CHRONIC

Due to (or as a consequence of):

b. RHABDOMYOLYSIS

Due to (or as a consequence of):

c. LEFT HIP FRACTURE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HTN, IDDM, CAD, anemia

CHF, sepsis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Pending  
Investigation  
3 ☐ Accident 4 ☐ Suicide  
5 ☐ Homicide 6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)  
6/10/2000

28b. Time of

Injury  
Night

28c. Injury at

Work?  
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

PATIENT FELL

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

HOME

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

3009 Manhattan Ave, Balto., Md

29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Heather Lee RESIDENT PHYSICIAN

29c. License number

RES-001

29d. Date signed (Month, Day, Year)

JUNE 17, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HEATHER LEE, MD SINAI HOSPITAL 3001 WEST BELVEDERE AVENUE

BALTIMORE, MD

21215

31. Date filed (Month, Day, Year)

JUL 07 2000

32. Registrar's Signature

[Signature]

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Thomas Sr, Leroy U

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

incorrect correction per diana barbour 7/3/00 yg

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22085

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Randolph Walker, Jr.

2. Date of Death

Month Day Year  
JULY 9, 2000

3. Time of Death

6:45 AM

4a. Facility Name (If not institution, give street and number)

4805 CORDELIA AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

218-80-1929

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

27 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT. 13 1972

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3508 W. Belverdere Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Maintenance Engineer

16b. Kind of Business/Industry

Maintenance

17. Father's Name (First, Middle, Last)

Charles Randolph Walker, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Linda Johnson

19a. Informant's Name/Relationship (Type, Print)

Linda J. Walker / mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4001 W. Wabash Ave 1B Balto. MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Date

Jul 15, 00

20c. Location - City or Town, State

Baltimore

21. Signature of Funeral Service Licensee

Ronald A. Grayson

22. Name and Address of Facility

Ronald A. Grayson Funeral Service  
8312 Liberty Rd. Balto. MD 21244

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ASPHYXIAATION DUE TO STRANGULATION ASSOCIATED  
WITH STAB AND CUTTING WOUNDS

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) AT SCENE

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

7/9/00

28b. Time of Injury

0640 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

SUBJECT WAS STRANGLED, STABBED, AND CUT

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

A RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

4805 CORDELIA AVE BALTIMORE MD

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John A. Leno

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARY G. RIPPKE, M.D. 111 Penn Street, Baltimore, Maryland 21201

31. Date filled (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

John A. Leno

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

00 22086

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley May Wain

2. Date of Death

Month Day Year  
July 5 2000

3. Time of Death

0840

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

218-36-5806

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 21, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Federalsburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

612 Jacks Lane

10f. Zip Code

21632

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Food Preparation

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Emmett Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Nettie Rohrback

19a. Informant's Name/Relationship (Type, Print)

George Edward Wain / husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

612 Jacks Lane, Federalsburg, Maryland 21632

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Cedar Hill Cemetery

Date

7/10/2000 Brooklyn Park, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ann Y. Zink

22. Name and Address of Facility

Hubbard Funeral Home, Inc.

4107 Wilkens Avenue, Baltimore, Maryland 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. atherosclerotic heart disease

15 years.

Due to (or as a consequence of):

b. congestive heart failure

8 days

Due to (or as a consequence of):

c. End stage renal disease dialysis dependent

4 months

Due to (or as a consequence of):

d. Diabetes mellitus

years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral vascular disease.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of causa  
of death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Syed I. Ali

29c. License number

D46020

29d. Date signed (Month, Day, Year)

7/5/00

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Syed I. Ali, MD 506 Idlewild Avenue, Easton, Maryland 21601

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

Syed I. Ali

State  
Registrar

Shirley Wain

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

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State of Maryland / Department of Health and Mental Hygiene

00 22087

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HATTIE WATERS

2. Date of Death

Month Day Year  
7/7/2000

3. Time of Death

2:55 AM

4a. Facility Name (If not institution, give street and number)

SOUTHERN MD. HOSPITAL

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

P G CO.

Funeral  
Director

5. Social Security Number

251 86 8384

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

S.C.

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGE

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

UPPER MARLBORO

10f. Zip Code

20772

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

JIM LITTLE

18. Mother's Name (First, Middle, Maiden Surname)

MARY LITTLE

19a. Informant's Name/Relationship (Type, Print)

WILLIAM McELVEEN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1631 CHILTON ST. BALTO. MD 21218

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State☒ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARBUTUS PARK

Date

7/14/2000

20c. Location - City or Town, State

ARBUTUS MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ESTEP BROTHERS FUNERAL HOME PA .  
1300 EUTAW PL BALTO. MD 21217

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Respiratory Failure

Approximate Interval Between Onset and Death

One week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Pneumonitis and Pleural effusion One week

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

urosepsis - Hypothermia  
Septicemia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ NoHospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation☐ Accident ☐ Could not be determined☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Essam YOUSSEF TELLAWI SOUTHERN MD HOSPITAL

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

Sandra G. Sparks

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 29d,30 per phys. G785 7/12/00 yg

## Certificate of Death

Reg. No.

00 22088

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vera K. Weinell

2. Date of Death

Month  
JulyDay  
7Year  
2000

3. Time of Death

10:00 P.M.

4a. Facility Name (If not institution, give street and number)

FutureCare- Canton Harbor

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-03-0792

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
8-24-08

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

155 Grundy Street

10f. Zip Code

21224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
7College (1-4or 5+)  
016a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Sales

16b. Kind of Business/Industry

Hess Shoe Store

17. Father's Name (First, Middle, Last)

Theodore Cioka

18. Mother's Name (First, Middle, Maiden Sumama)

Catherine Shriner

19a. Informant's Name/Relationship (Type, Print)

William Zybell / NEPHEW

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

203 Patapsco Ave Baltimore, Md 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Oak Lawn Cemetery

Date

7-12-00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Cvach/Rosedale Funeral Home

1211 Chesaco Avenue, Baltimore, MD 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Arterio-sclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Myocardial Vessel Disease

Due to (or as a consequence of):

c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28e. Date of Injury

(Month, Day, Year)

28b. Time of  
injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

024226

29d. Date signed (Month, Day, Year)

7/7/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Simon Scalia 2801 Foster Avenue 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
page.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



WHITNEY

**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

amend item 29d per me G785 7/12/00 yg

AMEND ITEMS: #23 078

### Certificate of Death

Reg. No.

00 22089

Physician /Medical Examiner

Barbara Janet Whitney

2. Date of Death Month Day Year JULY 8, 2000

3. Time of Death 18:35 PM

4a. Facility Name (If not institution, give street and number) SINAI HOSPITAL

4b. City, Town, or Location of Death BALTIMORE

4c. County of Death N/A

5. Social Security Number 030-05-8801

6. Sex 1 M 2 F

7. Age (In yrs. last birthday) 40 Yrs.

8. Date of Birth (Month, Day, Year) Jan. 21 1960

9. Birthplace (State or Foreign Country) West Virginia

10a. State Md.

10b. County Baltimore

10c. City, Town or Location Towson

10d. Inside City Limits 1 Yes 2 No

10e. Street and Number 1301 Brixton

10f. Zip Code 21286

10g. Citizen of What Country? USA

11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Handicapped

16b. Kind of Business/Industry N/A

17. Father's Name (First, Middle, Last) Waldo Danforth Whitney

18. Mother's Name (First, Middle, Maiden Surname) Jane Devonshire

19a. Informant's Name/Relationship (Type, Print) Ann Breihan/ Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4322 Cross Country Dr. Ellicott City, Md. 21042

20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) St Mary's Govans

20c. Location - City or Town, State Baltimore, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each time.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year) 7-6-00

28b. Time of Injury 8:50 M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred SUBJECT FELL ONTO SIDEWALK

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6300 BLK. SEAFORTH BALTIMORE, MD

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number OCME

29d. Date signed (Month, Day, Year) 7/10/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dennis Chute 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) 11 12 2000

32. Registrar's Signature

State Registrar

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MENTAL RETARDATION

SEIZURE DISORDER

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

Subdural Hematoma

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 22090

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SHARON WILSON

2. Date of Death

July 9 2000

3. Time of Death

11:10PM

4a. Facility Name (If not institution, give street and number)

Genesis ElderCare Caton Manor Baltimore

4b. City, Town, or Location of Death

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-80-2669

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

39

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

05 06 1961

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2223 Tucker Lane

10f. Zip Code

21207

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laundress

16b. Kind of Business/Industry

Lord Baltimore Laundry

17. Father's Name (First, Middle, Last)

William H. Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Deborah P. Wiley

19a. Informant's Name/Relationship (Type, Print)

Deborah P. Wilson (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2223 Tucker Lane B3 Balto., Md. 21207

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cemetery

Data

20c. Location - City or Town, State

7-14-00 Landsdowne, Maryland

21. Signature of Funeral Service Licensee

Dennis B. Caple

22. Name and Address of Facility

Caple Funeral Service  
5502 Winner Ave. Balto., Md. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC PANCREATIC CANCER 9 MOS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

deep venous THROMBOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis B. Caple

29c. License number

DS2360

29d. Date signed (Month, Day, Year)

7/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KULBIR SANDHU  
1835 GREENE TREE RD, SUITE 300 PICESVILLE MD 21208

31. Date filed (Month, Day, Year)

JUL 12 2000

32. Registrar's Signature

Dennis B. Caple

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22091

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roger H. Attick</b>				2. Date of Death Month <b>July</b> Day <b>1</b> Year <b>2000</b>				3. Time of Death <b>11:06 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>Calvert Manor Healthcare Center</b>				4b. City, Town, or Location of Death <b>Rising Sun</b>				4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>179-12-8550</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Apr. 11, 1922</b>		9. Birthplace (State or Foreign Country) <b>Delaware</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Rising Sun</b>				10d. Inside City Limits <b>1</b> Yes <b>2</b> No		
10e. Street and Number <b>1881 Telegraph Rd.</b>				10f. Zip Code <b>21911</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salesman</b>			16b. Kind of Business/Industry <b>Lumber</b>			
17. Father's Name (First, Middle, Last) <b>Roger E. Attick</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie M. Gross</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Barbara Herr</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1235 W. Penn Grant Rd., Lancaster, PA 17603</b>						
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Del Vet Cemetery</b>		Date <b>7-7-00</b>		20c. Location - City or Town, State <b>Bear, Delaware</b>				
21. Signature of Funeral Service Licensee <b>Richard L. Goodie</b>				22. Name and Address of Facility <b>R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>A.S.C.V.D</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown										
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No										
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial Fibrillation</b> <b>Congestive Heart Failure</b> <b>CVA &amp; Hemiplegia</b>										
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)								
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Neil R Taylor MD</b>		29c. License number <b>0-11115</b>		29d. Date signed (Month, Day, Year) <b>7-02-00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Neil R Taylor MD, Calvert Healthcare Center, Rising Sun MD 21911</b>										
31. Date filed (Month, Day, Year) <b>JUL 03 2000</b>		32. Registrar's Signature <b>Barbara B. Sparks</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1902

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22092

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY BASHAM

2. Date of Death

Month  
JULYDay  
5Year  
2000

3. Time of Death

1015 A M

4a. Facility Name (If not Institution, give street and number)

LAUREL REGIONAL HOSPITAL

4b. City, Town, or Location of Death

Laurel

4c. County of Death

PRINCE GEORGE

Funeral  
Director

5. Social Security Number

217-38-8184

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

June 17, 1940

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Mt. Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7435 Nathaniel Drive

10f. Zip Code

21771

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

Unknown

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harmon Burns

18. Mother's Name (First, Middle, Maiden Surname)

Arsula Williams

19a. Informant's Name/Relationship (Type, Print)

Vance Merson/Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7435 Nathaniel Drive, Mt. Airy, MD, 21771

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Meadowridge Memorial Pk

Date

7/7/00

20c. Location - City or Town, State

Elkridge, MD

21. Signature of Funeral Service Licensee

G. S. K.

MO0770

22. Name and Address of Facility

Donaldson Funeral Home, P.A.  
313 Talbott Avenue, Laurel, MD, 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Finest disease or condition resulting in death)

a. CELLULITIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. PERIPHERAL VASCULAR DISEASE

Due to (or as a consequence of):

6 MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA

MALNUTRITION

PERIPHERAL LUNG MASS RIGHT

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. Sparks

29c. License number

D39629

29d. Date signed (Month, Day, Year)

JULY 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALEXANDER SY MD 10724 LITTLE PATUXENT PKWY SUITE 200 COLUMBIA MD 21044

31. Date filed (Month, Day, Year)

JUL 07 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

2070 0000  
2070 0000

2070 0000

2070 0000 2070 0000

2070 0000

2070 0000

2070 0000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22093

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Carol Bright</b>		2. Date of Death Month Day Year <b>June 23 2000</b>		3. Time of Death <b>1:30 PM</b>													
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>Baltimore</b>													
Funeral Director	5. Social Security Number <b>205 42 2522</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>50</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>June 15 1950</b>	9. Birthplace (State or Foreign Country) <b>Lancaster, PA</b>													
	Usual Residence of Decedent																	
To Be Completed by Funeral Director	10a. State <b>PA</b>	10b. County <b>Lancaster</b>	10c. City, Town or Location <b>Lancaster</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
	10e. Street and Number <b>353 Meetinghouse Lane</b>		10f. Zip Code <b>17601</b>		10g. Citizen of What Country? <b>USA</b>													
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:													
	14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School Teacher</b>													
	16b. Kind of Business/Industry <b>Education</b>		17. Father's Name (First, Middle, Last) <b>Albert Breneman</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Jane Hess</b>													
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Shannon Bright</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>317 Meetinghouse Lane Lancaster, PA 17601</b>															
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evans Eagle Crematory</b>		20c. Location - City or Town, State <b>Leola, PA 17540</b>													
	21. Signature of Funeral Service Licensee <b>Jeffrey P. Lovelidge</b>		22. Name and Address of Facility <b>Harkins Funeral Home Inc. 600 Main Street Delta, PA 17314</b>															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
	23b. Approximate Interval Between Onset and Death																	
<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>Sepsis</b></td> <td>one day</td> </tr> <tr> <td>b.</td> <td><b>Cytomegalovirus infection</b></td> <td>one week</td> </tr> <tr> <td>c.</td> <td><b>Graft versus host disease</b></td> <td>one month</td> </tr> <tr> <td>d.</td> <td><b>Leukemia</b></td> <td>six months</td> </tr> </table>						Immediate Cause (Final disease or condition resulting in death)	a.	<b>Sepsis</b>	one day	b.	<b>Cytomegalovirus infection</b>	one week	c.	<b>Graft versus host disease</b>	one month	d.	<b>Leukemia</b>	six months
Immediate Cause (Final disease or condition resulting in death)	a.	<b>Sepsis</b>	one day															
	b.	<b>Cytomegalovirus infection</b>	one week															
	c.	<b>Graft versus host disease</b>	one month															
	d.	<b>Leukemia</b>	six months															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																		
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																		
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined																		
28a. Date of Injury (Month, Day Year)																		
28b. Time of Injury <b>M</b>																		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																		
28d. Describe how injury occurred																		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																		
28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																		
29b. Signature and title of certifier <b>Mark Lewis MD</b>																		
29c. License number <b>D0052391</b>																		
29d. Date signed (Month, Day, Year) <b>June 23, 2000</b>																		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mark Lewis Johns Hopkins Hospital Department of Oncology Baltimore, Maryland</b>																		
31. Date filed (Month, Day, Year) <b>JUN 28 2000</b>																		
32. Registrar's Signature <b>G. Sparks</b>																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

THE STATE OF TEXAS,  
COUNTY OF DALLAS.

I, the undersigned, Clerk of the County of Dallas, Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said County.

Given under my hand and the seal of said County, at Dallas, Texas, this 1st day of January, 1901.

CLERK OF COUNTY.

Attest:

My hand and seal of said County, at Dallas, Texas, this 1st day of January, 1901.

CLERK OF COUNTY.

Attest:

My hand and seal of said County, at Dallas, Texas, this 1st day of January, 1901.

CLERK OF COUNTY.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22094

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Walker Bailey, Sr.</b>				2. Date of Death Month Day Year <b>June 22, 2000</b>				3. Time of Death <b>7:05p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Harford Memorial Hospital</b>				4b. City, Town, or Location of Death <b>Havre de Grace</b>				4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>264-01-6214</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F <b>X</b>		7. Age (In yrs. last birthday) <b>85</b> Yrs.		If Under 1 Year Months Days <b>0 0</b>		8. Date of Birth (Month, Day, Year) <b>December 7, 1914</b>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Aberdeen</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No <b>X</b>		10e. Street and Number <b>439 Aldino-Stepney Road</b>		10f. Zip Code <b>21001</b>		10g. Citizen of What Country? <b>Maryland</b>			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Dairy Farmer</b>		16b. Kind of Business/Industry <b>Agriculture</b>					
	17. Father's Name (First, Middle, Last) <b>Hugh Boyle Bailey</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Ella(NMN)Walker</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>Helen Bailey / Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>439 Aldino-Stepney Road Aberdeen, Maryland 21001</b>							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gardens</b>		20c. Location - City or Town, State <b>6-26-00 Bel Air, Maryland</b>					
	21. Signature of Funeral Service Licensee <b>Charles A. Emge</b>		22. Name and Address of Facility <b>McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Cardiorespiratory Failure</b> Due to (or as a consequence of): <b>b. Pulmonary Embolism</b> Due to (or as a consequence of): <b>c. AFCD</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>June 22, 2000</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Luse E. Rangel</b>		29c. License number <b>D0002654</b>		29d. Date signed (Month, Day, Year) <b>6-22-00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Luse E. Rangel MD 464 Alliance St Havre de Grace, MD. 21078</b>		31. Data filed (Month, Day, Year) <b>JUN 28 2000</b>		32. Registrar's Signature <b>B. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at (410) 528-1234.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22095

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lois Ann Brown

2. Date of Death

June 30, 2000

3. Time of Death

2055

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

212-38-4916

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

July 18, 1940

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

700 West Belair Ave., Apt 232

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Physical Therapist

16b. Kind of Business/Industry

Hospital

17. Father's Name (First, Middle, Last)

George Waldon Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Doris Pugh

19a. Informant's Name/Relationship (Type, Print)

Kem Cooper / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

103 Bush Chapel Road, Aberdeen, MD 21001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Union United Methodist

Date

7/5/00

20c. Location - City or Town, State

Aberdeen, Maryland

21. Signature of Funeral Service Licensee

Lisa Scott

22. Name and Address of Facility

Lisa M. Scott Funeral Services

552 Lewis Street, Havre de Grace, MD 21078

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. CARDIOVASCULAR ACCIDENT.  
Due to (or as a consequence of):b.   
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MULTI INFARCT DEMENTIA- PARKINSONS- CARDIAC ARRHYTHMIA- TYPE II DIABETES

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

T. Biondo MD

29c. License number

D42800

29d. Date signed (Month, Day, Year)

7/1/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. Biondo 319 S. Canton Ave., HdB, Md., 21078

31. Date filed (Month, Day, Year)

JUL 03 2000

32. Registrar's Signature

B. B. Sparks

State  
Registrar

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar

Brown, Lois A. 6/30/00

Dr. Biondo

THE END

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22096

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Tyrrell Jeanine Bullock</b>						2. Date of Death Month Day Year <b>JUNE 17 2000</b>		3. Time of Death <b>2305</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>						4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>218-06-1445</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>36</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 29 1963</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>408 Lake Street</b>				10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>U.S.A</b>			
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>			16b. Kind of Business/Industry <b>None</b>			
	17. Father's Name (First, Middle, Last) <b>Andrew Stone</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Ada Bullock</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Lester Bullock (Brother)</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>408 Lake St. Salisbury, Md. 21801</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Springhill Mem. Garden</b>		Date <b>6/24/00</b>		20c. Location - City or Town, State <b>Hebron, Md.</b>			
	21. Signature of Funeral Service Licensee <i>[Signature]</i>						22. Name and Address of Facility <b>Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801</b>			
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>metastatic Breast Ca</b> Due to (or as a consequence of): b. <b>sepsis</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death <b>3 w</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>[Signature]</i> MD		29c. License number <b>D 20507</b>		29d. Date signed (Month, Day, Year) <b>6/15/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph A. Grasso 145 E. Carroll St Salisbury MD</b>										
31. Date filed (Month, Day, Year) <b>JUN 20 2000</b>			32. Registrar's Signature <i>[Signature]</i>							



00 22097

## Reg. No.

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22098

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN JAY BOOHER SR.				2. Date of Death Month Day Year JUNE 23, 2000		3. Time of Death 1:50PM	
	4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL MEDICAL CENTER				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 410 05 6098		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) JUNE 19, 1919	
	9. Birthplace (State or Foreign Country) TENNESSEE		10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location EDGEWATER	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number 1705 OLD TOWN ROAD		10f. Zip Code 21037		10g. Citizen of What Country? UNITED STATES		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1944-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (13-16) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TITLE CONTRACTOR		16b. Kind of Business/Industry CONSTRUCTION		17. Father's Name (First, Middle, Last) JOHN BOOHER		
18. Mother's Name (First, Middle, Maiden Surname) MARTHA AUSTIN		19a. Informant's Name/Relationship (Type, Print) BESSIE M. BOOHER (WIFE)		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1705 OLD TOWN ROAD EDGEWATER, MD. 21037		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) METROPOLITAN CREMATORY		20c. Location - City or Town, State ALEXANDRIA, VA.		21. Signature of Funeral Service Licensee		22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Respiratory failure Due to (or as a consequence of): b. Bacterial pneumonia Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death Days Days		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Gregory A. Mitchell, MD		
29c. License number D14758		29d. Date signed (Month, Day, Year) 6-25-00		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORY MITCHELL 621 Ridgely Ave Suite 401 ANNAP, MD 21401		31. Date filed (Month, Day, Year) JUN 27 2000		
32. Registrar's Signature B. Sparks								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

7005 P & MUL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22099

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Christine Christensen

2. Date of Death

Month

Day

Year

JUNE 26 2000

3. Time of Death

11:55 A

4a. Facility Name (If not institution, give street and number)

Lorien Nursing &amp; Rehabilitation Center

4b. City, Town, or Location of Death

Belcamp

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

224-24-3546

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jan. 23, 1923

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Churchville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

111 Calvary Road

10f. Zip Code

21028

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Hiday

U/K

Sprouse

18. Mother's Name (First, Middle, Maiden Surname)

Ressie Drewsilla

Gragg

19a. Informant's Name/Relationship (Type, Print)

Linda L. Herzberg-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

104 Village Greene Lane, Baltimore, Maryland 21220

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens June 29, 2000 Bel Air, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Coronary artery disease

Due to (or as a consequence of):

Degenerative Arthritis

Due to (or as a consequence of):

Arteriosclerotic Cardiovascular disease

Due to (or as a consequence of):

Chronic obstructive pulmonary disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

Prob 61

29d. Date signed (Month, Day, Year)

6/27/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. T. Lee, M.D. 669 Revolution St. HAVERDE GRACE, MD. 21072

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

[Signature]

State  
RegistrarDorothy C. Christensen  
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22100.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Doris Vivian Chenoweth

2. Date of Death

Month Day Year  
June 26, 2000

3. Time of Death

1:30 PM

4a. Facility Name (If not institution, give street and number)

310 S. Tollgate Road

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

220-03-5196

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 14, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

310 S. Tollgate Road

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Owner &amp; Operator

18b. Kind of Business/Industry

Saddlery

17. Father's Name (First, Middle, Last)

Raymond Bertrum Leight

18. Mother's Name (First, Middle, Maiden Surname)

Diana S. Schmidt

19a. Informant's Name/Relationship (Type, Print)

Carolynn Bredehoeft-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1403 Harvard Ct., Bel Air, Maryland 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cokesbury U. M. Cemetery

Data

6-30-00

20c. Location - City or Town, State

Abingdon, Maryland

21. Signature of Funeral Service Licensee

Stephen A. Hughes

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 1/2 years

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

JOAN P. EDWARDS M.D.

29c. License number

231775

29d. Date signed (Month, Day, Year)

JUNE 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOAN P. EDWARDS M.D.

2112 BELAIR ROAD FAUSTON, MARYLAND 21047

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22101

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Harold Henry Collins</b>					2. Date of Death Month Day Year <b>June 20 2000</b>		3. Time of Death <b>2325</b>			
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>					4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>			
Funeral Director	5. Social Security Number <b>216-16-7770</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 2, 1921</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent					10a. State <b>Maryland</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Berlin</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					10e. Street and Number <b>102 Flower Street</b>		10f. Zip Code <b>21811</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>self-employed laborer</b>		16b. Kind of Business/Industry <b>Landscaping Company</b>						
	17. Father's Name (First, Middle, Last) <b>Ernest Ccllins</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Bethards</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Sheila Gortman/daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4589 Penny Tree Place - Chantilly, VA 20151</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Paul Church Cemetery</b>		20c. Date <b>6/24/00</b>		20d. Location - City or Town, State <b>Berlin, Maryland</b>				
	21. Signature of Funeral Service Licensee <i>Patricia A. Jolley</i>					22. Name and Address of Facility <b>JOLLEY MEMORIAL CHAPEL 21801</b> <b>1213 Jersey Road - Salisbury, MD</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Stroke</b> Due to (or as a consequence of): <b>b. HTN</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last					Approximate Interval Between Onset and Death <b>2 weeks</b>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CRI</b>					23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
					24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
	29b. Signature and title of certifier <i>[Signature]</i>					29c. License number <b>154879</b>		29d. Date signed (Month, Day, Year) <b>06/21/00</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Greg Treuth, M.D.</b> <b>126 M. L. Dr. 1st St. S. L. 267 MD 21801</b>										
	31. Date filed (Month, Day, Year) <b>JUN 23 2000</b>		32. Registrar's Signature <i>[Signature]</i>								

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22102

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIVIAN DELORES CAUSEY

2. Date of Death

JUNE 20, 2000

3. Time of Death

0405

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

220-28-1740

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

DEC. 18, 1932

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State  
MARYLAND10b. County  
WICOMICO10c. City, Town or Location  
DELMAR

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

29886 CONNELLY MILL RD

10f. Zip Code

21875

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

RICHARD HASTINGS

18. Mother's Name (First, Middle, Maiden Surname)

ELEANOR WEST

19a. Informant's Name/Relationship (Type, Print)

DONNIE CAUSEY - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

29886 CONNELLY MILL RD DELMAR, MD 21875

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CAMBRIDGE CREMATORY

Date

6/21/00

20c. Location - City or Town, State

CAMBRIDGE, MARYLAND

21. Signature of Funeral Service Licensee

Robert W. Harris

22. Name and Address of Facility

BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804

705 E. MAIN ST.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HYPOVOLEMIA

Due to (or as a consequence of):

b. UPPER G.I. BLEED

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

HOURS

4 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEVERE ANEMIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

B. Sparks

29c. License number

D0055006

29d. Date signed (Month, Day, Year)

6/20/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOHAN BHAT MD 711 College Lane #6 Salisbury Md.

31. Date filed (Month, Day, Year)

JUN 21 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Handwritten text at the top center, possibly a title or header.

Handwritten text in the middle section, possibly a date or reference.

Handwritten text in the lower middle section, possibly a signature or name.

Handwritten text in the lower section, possibly a date or reference.

Handwritten text at the bottom of the page, possibly a footer or concluding note.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22103

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JULIE

DOWD

2. Date of Death

Month  
JUNEDay  
17Year  
2000

3. Time of Death

2030

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

499-32-9663

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

August 8, 1929

9. Birthplace (State or Foreign Country)

Missouri

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Fruitland

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

412 Forest Drive

10f. Zip Code

21826

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Technical Librarian

16b. Kind of Business/Industry

Chemical Industry

17. Father's Name (First, Middle, Last)

Wasil

Dobrovolsky

18. Mother's Name (First, Middle, Maiden Surname)

Maria

Yancheck

19a. Informant's Name/Relationship (Type, Print)

Richard H. Dowd/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

412 Forest Dr., Fruitland, MD 21826

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Wicomico Memorial Park

Date

6/22/00

20c. Location - City or Town, State

Salisbury, MD

21. Signature of Funeral Service Licensee

Heath R. Dewey

22. Name and Address of Facility

Holloway Funeral Home Professional Association  
501 Snow Hill Rd., Salisbury, MD 21804

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Sepsis - enterococcal

Due to (or as a consequence of):

b.

Large cell lymphoma

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

5 days

1 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph A. Grasso MD

29c. License number

D 20507

29d. Date signed (Month, Day, Year)

6/18/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph A. Grasso 145 E. Carroll St Salisbury MD

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 20 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Dowd Julie  
499-32-9663  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-524-2024.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22104

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RODNEY FRANCIS EWING

2. Date of Death

Month Day Year  
JUN 23 2000

3. Time of Death

14:50 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

FALLSTON GENERAL HOSPITAL

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

5. Social Security Number

209-30-1074

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 28, 1940

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

207 Fairwood Road

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

School Principal

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Robert Leroy Ewing

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Frances Anderson

19a. Informant's Name/Relationship (Type, Print)

Mrs. Pamela D. Stauffer-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

336 Logan Court, Abingdon, Maryland 21009

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corp.

Date

6/27/00

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

ASCVD.

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

DIABETES MELLITUS TYPE I.

DIABETIC KETOACIDOSIS

CANCER PROSTATE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.E.

29c. License number

D21809

29d. Date signed (Month, Day, Year)

JUN 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G. PRASHAD M.D. 728 BELAIR RD BELAIR MD 21014

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22105.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Jerry N. Farley</i>				2. Date of Death Month <i>June</i> Day <i>26</i> Year <i>2000</i>		3. Time of Death <i>11:55 AM</i>	
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Systems</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>	
Funeral Director	5. Social Security Number <i>161-20-4840</i>		6. Sex <i>152 M</i> <input type="checkbox"/> F		7. Age (In yrs. last birthday) <i>71</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>9/29/1928</i>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <i>West Virginia</i>		10a. State <i>MD</i>		10b. County <i>Harford</i>	
To Be Completed by Funeral Director	10c. City, Town or Location <i>Whiteford</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>1505 Main Street</i>		10f. Zip Code <i>21160</i>	
	10g. Citizen of What Country? <i>United States</i>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <i>WW 2 &amp; Korea</i>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
	14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>10</i> College (1-4 or 5+) <i>Superintendent of Bldgs. Civil Service</i>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
	17. Father's Name (First, Middle, Last) <i>Dewey Farley</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Leafie Blake</i>		19a. Informant's Name/Relationship (Type, Print) <i>Dorothy O. Farley - Wife</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1505 Main Street, Whiteford, MD 21160</i>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Slate Ridge Cemetery</i>		20c. Date <i>6/30</i>		20d. Location - City or Town, State <i>Delta, PA</i>	
	21. Signature of Funeral Service Licensee <i>Jeffrey P. Lovelady</i>		22. Name and Address of Facility <i>Harkins Funeral Home, Inc., Delta, PA</i>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Respiratory Arrest</i> Due to (or as a consequence of): <i>b. Cardiac Arrest</i> Due to (or as a consequence of): <i>c. Spontaneous Subarachnoid Hemorrhage</i> Due to (or as a consequence of): <i>d.</i>		Approximate Interval Between Onset and Death <i>I have</i>	
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29f. Signature and title of certifier <i>Donald</i>		29g. License number <i>AU476935R12450</i>		29h. Date signed (Month, Day, Year) <i>6/28/00</i>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>Bimal Ram</i>		31. Date filed (Month, Day, Year) <i>JUN 28 2000</i>		32. Registrar's Signature <i>B. A. Jones</i>		33. State Registrar		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1000 S 8 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22106

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELIZABETH SHIRLEY FUGETT

2. Date of Death

Month  
July

Day

1

Year

2000

3. Time of Death

10:45 AM

4a. Facility Name (If not institution, give street and number)

7550 Bensville Road

4b. City, Town, or Location of Death

Waldorf

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

284-24-8073

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 24, 1928

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7550 Bensville Road

10f. Zip Code

20603

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Roy Carter

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Bradley Carter

19a. Informant's Name/Relationship (Type, Print)

Elizabeth S. Griffith (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7550 Bensville Road Waldorf, MD 20603

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bradley Cemetery

Date

4-5-00

20c. Location - City or Town, State

Louisa, Kentucky

21. Signature of Funeral Service Licensee

M00173

22. Name and Address of Facility

Eberwein Funeral Services  
4433 White Pls. La. White Pls., MD 20695

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Breast Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

X ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

X ☒ 2 ☐

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Krishan Mathur

29c. License number

D28352

29d. Date signed (Month, Day, Year)

July 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 03 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



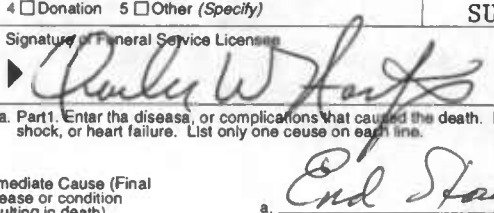
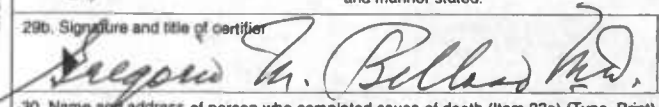
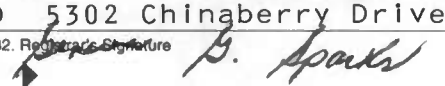
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 22107

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PETER ALAN FREEMAN</b>						2. Date of Death Month Day Year <b>June 20th 2000</b>		3. Time of Death <b>4:15 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Wicomico Nursing Home</b>						4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>092-20-7786</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 21, 1923</b>		9. Birthplace (State or Foreign Country) <b>CALIFORNIA</b>	
	Usual Residence of Decedent									
10a. State <b>MARYLAND</b>		10b. County <b>WICOMICO</b>		10c. City, Town or Location <b>WILLARDS</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>36029 COBBS HILL ROAD</b>				10f. Zip Code <b>21874</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1944-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>ENGINEER</b>				16b. Kind of Business/Industry <b>CONSULTING</b>		
17. Father's Name (First, Middle, Last) <b>STUART FREEMAN</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>MONICA SHARRETT</b>				
19a. Informant's Name/Relationship (Type, Print) <b>DOLORES T. FREEMAN/WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>36029 COBBS HILL ROAD, WILLARDS, MARYLAND 21874</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SUNSET MEMORIAL PARK</b>		20c. Date <b>6/23/00</b>		20d. Location - City or Town, State <b>BERLIN, MARYLAND</b>				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>End Stage Parkinson's Disease</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Seizure Disorder</b> <b>Sleep Apnea</b> <b>Peptic Ulcer Disease</b>										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D29505</b>		29d. Date signed (Month, Day, Year) <b>6-20-2000</b>				
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Gregorio Belloso, MD 5302 Chinaberry Drive Salisbury MD 21801</b>										
31. Date filed (Month, Day, Year) <b>JUN 22 2000</b>		32. Registrar's Signature 								

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,





00 22108.

ORIGINAL

DHMH 16 Rev 6/95





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22109

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Terry Glenn Fauver</b>				2. Date of Death Month Day Year <b>JUNE 23, 2000</b>				3. Time of Death <b>2300 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>WATERFORD PARK</b>				4b. City, Town, or Location of Death <b>PASADENA</b>				4c. County of Death <b>ANNE ARUNDEL</b>	
Funeral Director	5. Social Security Number <b>214-62-1152</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>46</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Mar 11, 1954</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Odenton</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>1204 Winer Road</b>				10f. Zip Code <b>21113</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. <b>White</b> Specify:		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Auto Mechanic</b>				16b. Kind of Business/Industry <b>Automotive</b>		
17. Father's Name (First, Middle, Last) <b>Earl Fauver</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Pace</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Judy Fauver/ wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1204 Winer Road, Odenton, MD 21113</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>June 26, 2000</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>				
21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Barranco &amp; Sons, P.A. Severna Park Funeral Home</b> <b>495 Gov. Ritchie Hwy., Severna Park, MD 21146</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Contact Shotgun wound of chest</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b>								
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>Found 6-23-2000</b>		28b. Time of Injury <b>unknown</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject shot self</b>		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Motor vehicle</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Anne Arundel county, Maryland</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>[Signature]</i> <b>Steph A. Radentz, MD</b>				29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JUNE 24, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>JUN 27 2000</b>		32. Registrar's Signature <i>[Signature]</i>								

GOODS T S MUL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 22110**  
**Certificate of Death** Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Anne Madylen Gillinger</b>				2. Date of Death Month Day Year <b>June 18, 2000</b>		3. Time of Death <b>11:30 A.M.</b>	
	4e. Facility Name (If not Institution, give street and number) <b>94 Waterwheel Drive</b>				4b. City, Town, or Location of Death <b>Port Deposit</b>		4c. County of Death <b>Cecil</b>	
Funeral Director	5. Social Security Number <b>123-01-3386</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 24, 1912</b>	
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>MD</b>		10b. County <b>Cecil</b>		10c. City, Town or Location <b>Port Deposit</b>	
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>94 Waterwheel Drive</b>		10f. Zip Code <b>21904</b>		
10g. Citizen of What Country? <b>U.S.A.</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>In home</b>		
17. Father's Name (First, Middle, Last) <b>Vincent Desht</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Catherine Pavlik</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Gary Zeigler (step grandson)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>94 Waterwheel Drive, Port Deposit, MD 21904</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Harford Memorial Gardens</b>		Date <b>6/22/00</b>		20c. Location - City or Town, State <b>Aberdeen, Maryland</b>		
21. Signature of Funeral Service Licensee <i>Husken Ampley Unglesbee</i>				22. Name and Address of Facility <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <i>Atherosclerotic cardiovascular disease</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____							Approximate Interval Between Onset and Death <b>unknown</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>[Signature]</i>				29c. License number <b>D31712</b>		29d. Date signed (Month, Day, Year) <b>6/20/00</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Charles Earl Jr 49 W. BALTIMORE AVE ABERDEEN, MD 21001</b>								
31. Date filed (Month, Day, Year) <b>JUN 20 2000</b>				32. Registrar's Signature <i>[Signature]</i>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
 To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Handwritten text, possibly a signature or name, located in the middle-left section of the page.

Handwritten text at the bottom of the page, including what appears to be a date "JUN 8 1961" and other illegible markings.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 22111

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Billy (NMN) Gerhardt II</b>					2. Date of Death Month Day Year <b>June 29 2000</b>		3. Time of Death <b>6 45 A</b>			
	4a. Facility Name (If not institution, give street and number) <b>Mariner Health of Bel Air</b>					4b. City, Town, or Location of Death <b>Bel Air</b>		4c. County of Death <b>Harford</b>			
Funeral Director	5. Social Security Number <b>216-38-4979</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>59</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 21, 1941</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent					10c. City, Town or Location <b>Abingdon</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Abingdon</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>3425 Tree Frog Ct.</b>					10f. Zip Code <b>21009</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>5+</b>					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Owner/Operator</b>			16b. Kind of Business/Industry <b>Music</b>			
17. Father's Name (First, Middle, Last) <b>William Henry Gerhardt</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Anna Hlavac</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Donald Brand/ Personal Rep.</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1440 Stafford Rd., Darlington, MD 21034</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Hilltop Service Corp. 7-3-00</b>			Date <b>7-3-00</b>		20c. Location - City or Town, State <b>Towson, Maryland</b>			
21. Signature of Funeral Service Licensee <i>Stella McComas Pennington</i>					22. Name and Address of Facility <b>McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 21014</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Interstitial Pulmonary Fibrosis</b> Due to (or as a consequence of): b. <b>Diabetes Mellitus Type 2</b> Due to (or as a consequence of): c. <b>Hypertension</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>1yr.</b>											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier <i>Stephen G. Smaldore</i>			29c. License number <b>H40583</b>			29d. Date signed (Month, Day, Year) <b>6/29/00</b>					
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <b>Stephen G. Smaldore, 2021 B Emmerton Rd Ste 114 Bel Air Md 21015</b>											
31. Date filed (Month, Day, Year) <b>JUN 30 2000</b>			32. Registrar's Signature <i>B. Sparks</i>								

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

10

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22112

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RALPH M. GIBSON

2. Date of Death

JUNE 21 2000

3. Time of Death

1704

4a. Facility Name (If not institution, give street and number)

ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death

ANNAPOLIS

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

213-12-4876

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

JULY 24 1920

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

ANNE ARUNDEL

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1807 LINCOLN DRIVE

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1953

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

TRANSPORTATION DEPT.

16b. Kind of Business/Industry

US NAVAL ACADEMY

17. Father's Name (First, Middle, Last)

BERNARD GIBSON

18. Mother's Name (First, Middle, Maiden Surname)

MYRTLE BUTLER

19a. Informant's Name/Relationship (Type, Print)

MARJORIE Q. GIBSON (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1807 LINCOLN DR. ANNAPOLIS, MD. 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERAN

Date

6/27/00 CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee

Larry S. Reese

22. Name and Address of Facility

WM. REESE & SONS MORTUARY, P.A.  
821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Septic Shock

Approximate Interval Between Onset and Death

24 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):  
Perforated Bowel

24 hr

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven Resnick

29c. License number

DM35494

29d. Date signed (Month, Day, Year)

6/21/2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Steven Resnick Anne Arundel Medical Center

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

B. Spots

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1005 8 2 JUL

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22113

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM R. HENDERSON

2. Date of Death  
Month Day Year  
JUNE 20 20003. Time of Death  
7:23 pm

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

213-32-8245

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN. 5 1933

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12408 STURDEE DRIVE

10f. Zip Code

20772

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates

1953-56

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

2 yrs.

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)  
UTILITIES SYSTEM REPAIR  
OPERATOR

16b. Kind of Business/Industry

NATIONAL INSTITUTES  
OF HEALTH

17. Father's Name (First, Middle, Last)

THOMAS HENDERSON

18. Mother's Name (First, Middle, Maiden Surname)

BESSIE JONES

19a. Informant's Name/Relationship (Type, Print)

WILLIAM R. HENDERSON JR. (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20772  
12408 STURDEE DR. UPPER MARLBORO, MD.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

HILL CREST CEMETERY

Date

6/27/00

20c. Location - City or Town, State

ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee

Larry G. Reese

22. Name and Address of Facility

WM. REESE &amp; SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MASSIVE HEPATIC FAILURE

Due to (or as a consequence of):

b. HEPATITIS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

METASTASIS PROSTATE CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

XX Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

XX Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

XX Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

B. F. Reagan

29c. License number

D0045121

29d. Date signed (Month, Day, Year)

6/22/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIAN F. REAGAN 1500 FOREST GLEN AVE. SILVER SPRING, MD.

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

B. F. Reagan

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

JUL 5 1960

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22114

Physician  
(Medical  
Examiner)

1. Decedent's Name (First, Middle, Last)

Raymond Joseph Hoerl

2. Date of Death

Month Day Year

June 21,

2000

3. Time of Death

9:00 am

4a. Facility Name (If not institution, give street and number)

115 Roosevelt Avenue

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

219-18-1698

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 16, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

115 Roosevelt Avenue

10f. Zip Code

21061

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Foreman

16b. Kind of Business/Industry

Sugar

Manufacturing

17. Father's Name (First, Middle, Last)

Charles J. Hoerl

18. Mother's Name (First, Middle, Maiden Surname)

Mary Virginia Carson

19a. Informant's Name/Relationship (Type, Print)

James McDermott/ friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3501 Cokesbury Court, Pasadena, MD 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Cemetery

Date

June 27  
2000

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cancer of Colon Rect 2 months

Approximate Interval Between Onset and Death

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diverticulosis

Chronic Lung Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

795 Belvidere Road, Glen Burnie, Maryland 21061

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

S. Spots

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2000.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



0005 T 9 JUL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22115

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Phillip James, Sr.

2. Date of Death

Month  
JuneDay  
27Year  
2000

3. Time of Death

10:15 am

4a. Facility Name (If not institution, give street and number)

VA MEDICAL CENTER FORT HOWARD, MARYLAND

4b. City, Town, or Location of Death

FORT HOWARD

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

271-32-2183

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
05-13-40

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Edgewood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

736 Sequoia Drive

10f. Zip Code

21040

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates 1958-6013. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Auto Mechanic

16b. Kind of Business/Industry

Engine Repair Shop

17. Father's Name (First, Middle, Last)

Frank Stanley James

18. Mother's Name (First, Middle, Maiden Surname)

Priscilla Martha Straub

19a. Informant's Name/Relationship (Type, Print)

Ann Veronica James/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

736 Sequoia Drive, Edgewood, Maryland 21040

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hilltop Service Corp.

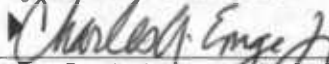
Date

6-30-00

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, MD 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Lung Cancer with Metastasis

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

one year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒

Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Aurora C. Tan, M.D.

29c. License number

D14958

29d. Date signed (Month, Day, Year)

June 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Aurora Tan, M.D. 9600 North Point Road, Fort Howard, Maryland 21052

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature



ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22116

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Debra Jeanne Kaufman</b>				2. Date of Death Month <b>July</b> Day <b>5</b> Year <b>2000</b>		3. Time of Death <b>7:30pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>533 Palisades Boulevard</b>				4b. City, Town, or Location of Death <b>Crownsville</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>212-58-7887</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>51</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb 2, 1949</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Crownsville</b>	
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>533 Palisades Boulevard</b>		10f. Zip Code <b>21032</b>		
10g. Citizen of What Country? <b>United States</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		
14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Horace Cugle Jr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Odessa Fissell</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Cobey L. Kaufman/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>533 Palisades Boulevard Crownsville, MD 21032</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Meadowridge Memorial Park</b>		20c. Location - City or Town, State <b>7-8-2000 Elkridge, Maryland</b>		20d. Date		
21. Signature of Funeral Service Licensee <b>Shirley A. Collier - Witzke</b>				22. Name and Address of Facility <b>Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Pulmonary Fibrosis</b> Due to (or as a consequence of): <b>Thrombocytopenia</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>4 mos.</b> <b>17 yrs.</b>		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Fibromyalgia</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Shirley A. Collier - Witzke</b>				29c. License number <b>031551</b>		29d. Date signed (Month, Day, Year) <b>July 6, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Russell R. Delaney 16005-Crown Highway Glen Burnie, Md 21061</b>								
31. Date filed (Month, Day, Year) <b>JUL 06 2000</b>		32. Registrar's Signature <b>Denise B. Sparks</b>						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

## State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Amend Item#16b HCHD 7/6/00

brh

Reg. No.

00 22117

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Richard Lee Kram

2. Date of Death

Month Day Year  
June 28 2000

3. Time of Death

3:15 am

4a. Facility Name (If not institution, give street and number)

611 Sandray Terrace

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

215-56-4963

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 11, 1952

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

611 Sandray Terrace

10f. Zip Code

21015

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Police Officer

16b. Kind of Business/Industry

Baltimore County

Police  
~~Baltimore City Police~~

17. Father's Name (First, Middle, Last)

Melvin M. Kram

18. Mother's Name (First, Middle, Maiden Summa)

Mary E. Gourley

19a. Informant's Name/Relationship (Type, Print)

Nanette M. Gebhardt-Kram (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

611 Sandray Terrace, Bel Air, MD 21015

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Joseph Church Cem.

Date

7/1/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.  
610 W. MacPhail Road, Bel Air, MD 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Transitional Cell Carcinoma of Urinary Bladder

Approximate Interval Between Onset and Death

4 years

Due to (or as a consequence of):

metastatic to liver

6 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

042979

29d. Date signed (Month, Day, Year)

June 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 N. Wolfe Street Baltimore MD 21287

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.





Joseph Klaus Jr.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27 PER MEO G786 8-18-00 VB  
amend item 8 per fn G788 10/5/00 yf

## Certificate of Death

Reg. No.

00 22118

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Baby Joseph L. Klaus</b>				2. Date of Death Month <b>July</b> Day <b>09</b> , Year <b>2000</b>				3. Time of Death <b>738 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>				4b. City, Town, or Location of Death <b>Essex</b>				4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>N/A</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>0</b> Yrs.		If Under 1 Year Months <b>1</b> Days <b>1</b>		8. Date of Birth (Month, Day, Year) <b>June 8, 2000</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>									
Usual Residence of Decedent										
10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>8110 Belair Road</b>				10f. Zip Code <b>21236</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Infant</b>				16b. Kind of Business/Industry <b>N/A</b>		
17. Father's Name (First, Middle, Last) <b>Joseph Klaus</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Gina Lorenzo</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Mrs. Gina L. Klaus (mother)</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8110 Belair Rd., Baltimore, MD 21236</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Joseph Church Cemetery</b>				20c. Location - City or Town, State <b>7/13/00 Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee 					22. Name and Address of Facility <b>Schimunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>SUDDEN INFANT DEATH SYNDROME</b>										
23b. Approximate Interval Between Onset and Death										
23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier 					29c. License number <b>O.C.M.E.</b>			29d. Date signed (Month, Day, Year) <b>July 10, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis Chuteau 111 Penn Street, Baltimore, Maryland 21201</b>										
State Registrar		31. Date filed (Month, Day, Year) <b>JUL 12 2000</b>		32. Registrar's Signature 						

ORIGINAL



00 22119

## Reg. No.

ORIGINAL

**Medical Certification: To Be Completed by Physician/Medical Examiner**



1000 1 1 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22120

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEONARD MONGOLD</b>				2. Date of Death Month <b>JUNE</b> Day <b>26<sup>TH</sup></b> Year <b>2000</b>		3. Time of Death <b>13:13</b>		
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>213-01-0611</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>93</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>AUG. 15, 1906</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent				10e. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U. S. A.</b>		10e. Street and Number <b>3812 Lyndale Avenue</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1942-1945</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Machinist</b>		16b. Kind of Business/Industry <b>Crown Cork &amp; Seal</b>				
	17. Father's Name (First, Middle, Last) <b>Adam M. Mongold</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary E. Holsinger</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>Arthur L. Drager, Atty.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 Light Street, Suite 510, Baltimore, Md. 21202</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		20c. Location - City or Town, State <b>6/29/00 Baltimore, Maryland</b>				
	21. Signature of Funeral Service Licensee <b>Mark T. [Signature]</b>		22. Name and Address of Facility <b>Schimunek Funeral Home Inc. 3331 Brehms Lane, Baltimore, Maryland 21213</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. SEVERE GASTRO INTESTINAL BLEEDING.</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):								
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No									
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CARDIOMYOPATHY</b> <b>ARTERIOSCLEROSIS.</b>								
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>MD. [Signature]</b>		29c. License number <b>D42723</b>		29d. Date signed (Month, Day, Year) <b>JUNE 26<sup>TH</sup> 2000</b>		
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AVVERAIALI M HARISH. RANDALLSTOWN MD 21133.</b>								
	31. Date filed (Month, Day, Year) <b>JUN 30 2000</b>				32. Registrar's Signature <b>[Signature]</b>				
	State Registrar								





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22121

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LOUIS MCGOWAN III

2. Date of Death

JUNE 22 2000

3. Time of Death

2:25 am

4a. Facility Name (If not institution, give street and number)

GILCREST HOSPICE CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

219-26-2906

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

OCT. 18 1939

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND ANNE ARUNDEL

10b. County

10c. City, Town or Location

ANNAPOLIS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

20 ALDER ROAD

10f. Zip Code

21403

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11thCollege (1-4 or 5+)  
0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

PLUMMER

16b. Kind of Business/Industry

US NAVAL ACADEMY

17. Father's Name (First, Middle, Last)

LOUIS MCGOWAN JR.

18. Mother's Name (First, Middle, Maiden Surname)

HILDA JASON

19a. Informant's Name/Relationship (Type, Print)

MARTINI BEAN (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20 ALDER RD. ANNAPOLIS, MD. 21403

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ANNAPOLIS MEM. GARDENS

Date

6/27/00 ANNAPOLIS, MD.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Larry A. Reese

22. Name and Address of Facility

WM. REESE &amp; SONS MORTUARY, P.A.

821 WEST ST. ANNAPOLIS, MD. 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Squamous cell cancer of Larynx*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*small cell cancer of lung*

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

W. A. Riley

29c. License number

025205

29d. Date signed (Month, Day, Year)

June 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Riley 6701 N. Charles St. Balto. Md

31. Date filed (Month, Day, Year)

JUN 27 2000

Registrar's Signature

P. Sparks

21204

State  
Registrar

JUNE 22, 2000 @ 2:25 AM

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 26a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.MCGOWAN, LOUIS  
Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22122

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>RUTH MELVIN</b>					2. Date of Death Month <b>6</b> Day <b>23</b> Year <b>00</b>		3. Time of Death <b>02:41</b>			
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>					4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>			
Funeral Director	5. Social Security Number <b>256-24-9667</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>80</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 19, 1920</b>		9. Birthplace (State or Foreign Country) <b>Georgia</b>		
	Usual Residence of Decedent					10c. City, Town or Location		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
10a. State <b>Florida</b>		10b. County <b>Sarasota</b>		10c. City, Town or Location <b>Sarasota</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>3014 Regatta Drive</b>					10f. Zip Code <b>34231</b>		10g. Citizen of What Country? <b>USA</b>				
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>					16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>Own Home</b>			
17. Father's Name (First, Middle, Last) <b>John William Buchan</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Lizzie Solomon</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Sharon Kay Chappell/ Daughter</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1203 John Ross Court Crownsville, Md. 21032</b>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Evergreen Cemetery</b>			Date <b>06-25-00</b>		20c. Location - City or Town, State <b>Fitzgerald, Georgia</b>			
21. Signature of Funeral Service Licensee <b>E. Brian Powell</b>					22. Name and Address of Facility <b>John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Maryland 21401</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive Heart Failure</b> <b>b. Severe Lactic Acidosis</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> <b>d.</b>										Approximate Interval Between Onset and Death <b>71 year</b> <b>24 hr</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
										24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. Signature and title of certifier <b>Robert T. Peterson</b>	
29c. License number <b>D24804</b>					29d. Date signed (Month, Day, Year) <b>6-23-00</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Robert T. Peterson 600 Ridge Ave Annapolis Md 21401</b>											
31. Date filed (Month, Day, Year) <b>JUN 27 2000</b>					32. Registrar's Signature <b>B. Sparks</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1005 T S MUL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22123

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Rebecca Elizabeth McKown						2. Date of Death Month Day Year June 21 2000		3. Time of Death 11:47 PM	
	4a. Facility Name (If not institution, give street and number) 48 Lawrence Ave.						4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 163-46-2261		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 47 Yrs.		8. Date of Birth (Month, Day, Year) June 7, 1953		9. Birthplace (State or Foreign Country) Pennsylvania	
	Usual Residence of Decedent									
10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Annapolis				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 48 Lawrence Ave.				10f. Zip Code 21403		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Vice President			16b. Kind of Business/Industry Banking			
17. Father's Name (First, Middle, Last) John Olynik						18. Mother's Name (First, Middle, Maiden Surname) Veronica Varadi				
19a. Informant's Name/Relationship (Type, Print) Michael McKown / husband						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 Lawrence Ave. Annapolis, MD. 21403				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) St. Demetrios Cemetery		Date 6-24-00		20c. Location - City or Town, State Annapolis, MD		
21. Signature of Funeral Service Licensee C. Brian Powell				22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Glioblastoma Multiforme Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death 3 yrs
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Jon Lowe, M.D.				29c. License number D18529		29d. Date signed (Month, Day, Year) 06-22-2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jon Lowe, M.D. 2007 Tidewater Colony Annapolis, Md. 21401										
31. Date filed (Month, Day, Year) JUN 27 2000				32. Registrar's Signature B. Spade						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Wash. D. C. 20005 P. S. MAIL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22124

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lillian L. O'Connor

2. Date of Death

06 25 2000

3. Time of Death

03:25A

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

213-03-6302

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

07-10-15

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

130 Hearne Road

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

Ferdinand Smith

18. Mother's Name (First, Middle, Maiden Surname)

Florence Briggs

19a. Informant's Name/Relationship (Type, Print)

Ronald Saunders/ son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2967 Mallview Road, Baltimore, MD 21230

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

June 27 2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov. Ritchie Hwy., Severna Park, MD 21146

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Cardiomyopathy

Due to (or as a consequence of):

b. Myocardial Infarction

Due to (or as a consequence of):

c. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

d. Diabetes Mellitus

Approximate Interval Between Onset and Death

1 yr

9 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypercholesterolemia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ NoHospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide ☐ Could not be determined  
☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D41034

29d. Date signed (Month, Day, Year)

June 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvatore S. Lauria, MD 2003 Medical Parkway, Suite 100, Annapolis, MD 21401

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

21-01-12

21

21-01-12

21-01-12  
21-01-12  
21-01-12

21-01-12

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21-01-12  
21-01-12

21-01-12



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22125

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Audrey Evans Price

2. Date of Death

June 25, 2000

3. Time of Death

7:35 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

956 F. Hillswood Road

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

5. Social Security Number

218-09-8065

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 5, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Bel Air

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

956 F. Hillswood Road

10f. Zip Code

21014

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Clarence Edward Evans

18. Mother's Name (First, Middle, Maiden Surname)

Maud Lillian Evans

19a. Informant's Name/Relationship (Type, Print)

Walter R. Price-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10 S. Atwood Road, Bel Air, Maryland 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gunpowder Meeting House

Date

June 30, 2000

20c. Location - City or Town, State

Sparks, Maryland

21. Signature of Funeral Service Licensee

Stephen G. Sualdero

22. Name and Address of Facility

McComas Funeral Home, P.A.

50 W. Broadway Street, Bel Air, Maryland 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Valvular Heart Disease

Due to (or as a consequence of):

b. Atrial Fibrillation

Due to (or as a consequence of):

c. Congestive Heart Failure

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Stephen G. Sualdero

29c. License number

H40583

29d. Date signed (Month, Day, Year)

6/27/00

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Stephen G. Sualdero

2021 B Emmorton Rd Bel Air

Md 21015

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

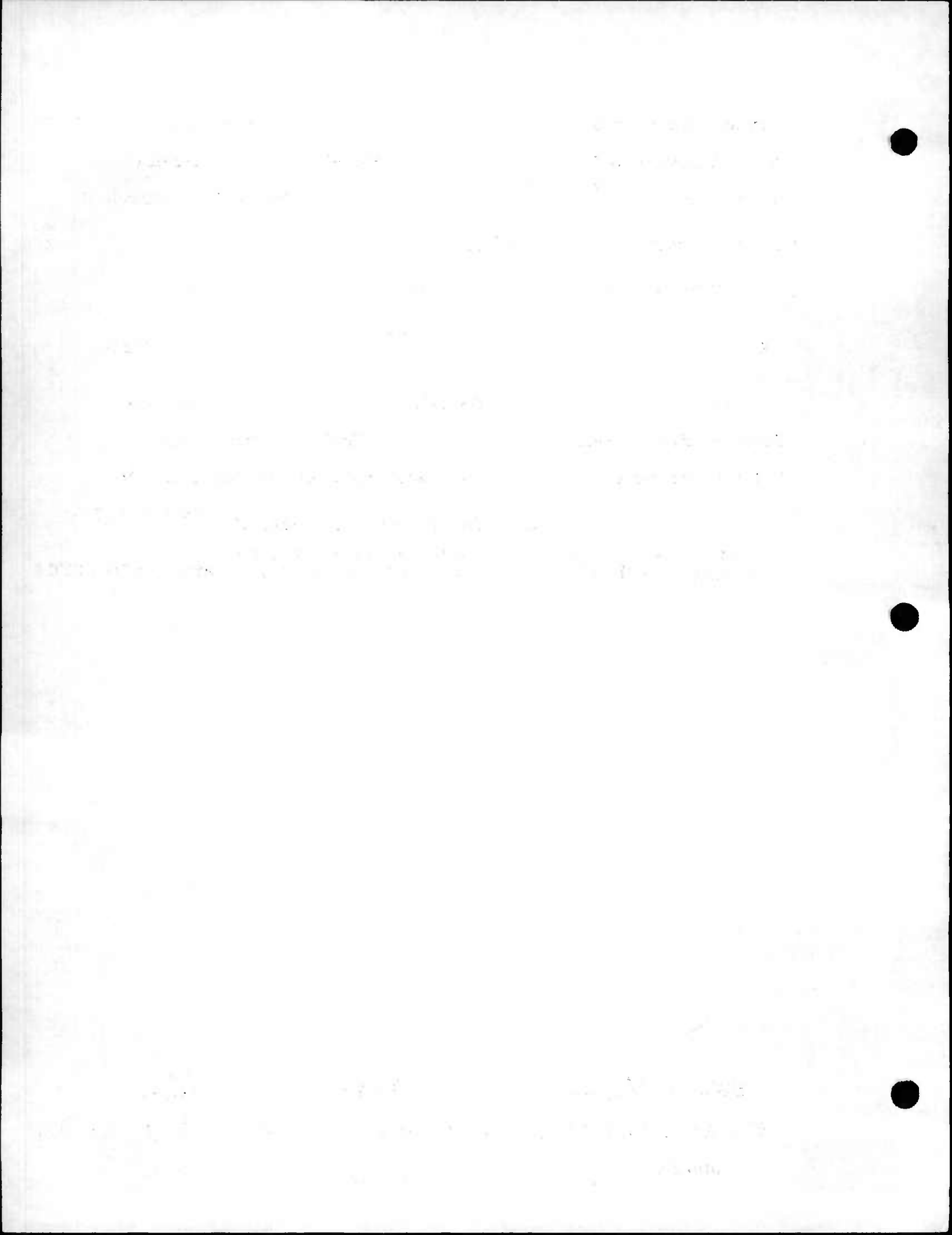
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22126

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NAOMI MAY POOLE

2. Date of Death

Month Day Year  
JUNE 27 2000

3. Time of Death

5:00 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MARINER HEALTH OF FOREST HILL

4b. City, Town, or Location of Death

FOREST HILL

4c. County of Death

HARFORD

5. Social Security Number

215-18-1937

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 23, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

109 Forest Valley Dr.

10f. Zip Code

21050

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Thomas Neidlein

18. Mother's Name (First, Middle, Maiden Surname)

Della Rebecca Burkentine

19a. Informant's Name/Relationship (Type, Print)

Jeanne M. Poole - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7358 Broken Staff, Columbia, Maryland 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Angel Hill Cemetery

Date

6/29/00

20c. Location - City or Town, State

Havre de Grace, MD

21. Signature of Funeral Service Licensee

Hilly M. Comas Pennington

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Anteroselebotec Cardiovascular disease

Due to (or as a consequence of):

b. Cerebrovascular accident

Due to (or as a consequence of):

c. Dementia

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. T. Lee, M.D. 1609 Revolution St. Havre de Grace, Md.

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

A. Spade

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-0000.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL

2000 2 14

JUN 20 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22127

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANDREW M. PIVEC

2. Date of Death

Month Day Year  
June 27, 2000

3. Time of Death

11:50 a.m.

4a. Facility Name (If not institution, give street and number)

15 Eastford Court

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-10-4954

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 27, 1916

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15 Eastford Court

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1945-4613. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Draftsman

16b. Kind of Business/Industry

Aerospace Industry

17. Father's Name (First, Middle, Last)

John Frank Pivec

18. Mother's Name (First, Middle, Maiden Surname)

Rose Duda

19a. Informant's Name/Relationship (Type, Print)

Emily Pivec (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Eastford Court, Baltimore, MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gardens of Faith Cem.

Date

6/30/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

► *Mark T. R...*

22. Name and Address of Facility

Schmunek Funeral Home, Inc.  
9705 Belair Road, Baltimore, MD 2123623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. *congestive heart failure*  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death*6 months*Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *cardiomyopathy*  
Due to (or as a consequence of):*years*c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

► *George Lowe MD*

29c. License number

D20673

29d. Date signed (Month, Day, Year)

6-28-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George Lowe MD 7612 Belair Rd Baltimore, MD 21236

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

*George B. Sparks*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2025.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22128

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Clifford Postley, Jr.

2. Date of Death

Month Day Year  
June 14, 2000

3. Time of Death

0006

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

214-60-8897

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 7, 1956

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Wicomico

10c. City, Town or Location

Salisbury

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

28712 Ocean Gateway

10f. Zip Code

21801

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

laborer

16b. Kind of Business/Industry

Dove Point

17. Father's Name (First, Middle, Last)

John Clifford Postley, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Laura Jester

19a. Informant's Name/Relationship (Type, Print)

Christine H. Postley/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28712 Ocean Gateway - Salisbury, MD 21801

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Springhill Memory Garden

Date

6/23/00

20c. Location - City or Town, State

Hebron, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

1213 Jersey Road - Salisbury, MD  
JOLLEY MEMORIAL CHAPEL 21801

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Congestive Heart Failure

Due to (or as a consequence of):

Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 30743

29d. Date signed (Month, Day, Year)

6/16/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Benjamin H. Meyer, M.D. 400 EASTERN SHORE DR. SALISBURY, MD 21804

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 20 2000

32. Registrar's Signature

ORIGINAL

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2000.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Handwritten text, possibly a signature or date, appearing in the center of the page.

Handwritten letter 'V'.

Handwritten letter 'X'.

Handwritten letter 'Z'.

Handwritten letter 'Y'.

Handwritten letter 'X'.

Handwritten text, possibly a date or initials.

Handwritten text, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22129

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>KAREN DAUGHERTY PHILLIPS</b>				2. Date of Death Month Day Year <b>June 17, 2000</b>		3. Time of Death <b>6:51 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1107 Frederick Ave.</b>				4b. City, Town, or Location of Death <b>Salisbury</b>		4c. County of Death <b>Wicomico</b>	
Funeral Director	5. Social Security Number <b>217-54-5388</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>36</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>June 19, 1963</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Wicomico</b>		10c. City, Town or Location <b>Salisbury</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>1107 Frederick Ave.</b>				10f. Zip Code <b>21801</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Regional Planner</b>			16b. Kind of Business/Industry <b>State Agency</b>	
17. Father's Name (First, Middle, Last) <b>Wayne M. Daugherty</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Betty A. Henderson</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Daniel K. Phillips/Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1107 Frederick Ave., Salisbury, MD 21801</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Wicomico Memorial Park</b>		Data <b>6/21/00</b>		20c. Location - City or Town, State <b>Salisbury, MD</b>		
21. Signature of Funeral Service Licensee <b>Keith R. Downey</b>				22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Carcinoma of Ovary</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>5 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>030690</b>		29d. Date signed (Month, Day, Year) <b>June 20, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James E. Martin, M.D., 1495 E. Carroll St., Salisbury, MD.</b>								
31. Date filed (Month, Day, Year) <b>JUN 20 2000</b>				32. Registrar's Signature <b>[Signature]</b>				

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22130

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Brice DeWitt Renn

2. Date of Death

Month  
July 5

Day

Year  
2000

3. Time of Death

4:00 am

4a. Facility Name (If not Institution, give street and number)

4610 Sandy Spring Road

4b. City, Town, or Location of Death

Burtonsville

4c. County of Death

Montgomery

5. Social Security Number

214-18-2345

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)  
Jan. 2, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Burtonsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4610 Sandy Spring Road

10f. Zip Code

20866

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

William D.c. Renn

18. Mother's Name (First, Middle, Maiden Surname)

Alice Connell

19a. Informant's Name/Relationship (Type, Print)

Robert Renn/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15200 McKnew Road, Burtonsville, MD, 20866

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Union Cemetery

Date

7/8/00

20c. Location - City or Town, State

Burtonsville, MD

21. Signature of Funeral Service Licensee

Greg S. K...

MO0770

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Avenue, Laurel, MD, 20707

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

PULMONARY EMBOLISM

Approximate Interval Between Onset and Death

HOURS

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Deepak Cuddapada

29c. License number

D0051867

29d. Date signed (Month, Day, Year)

July 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Deepak Cuddapada, M.D. 3905 National Blvd. Burtonsville, Md.

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 07 2000

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

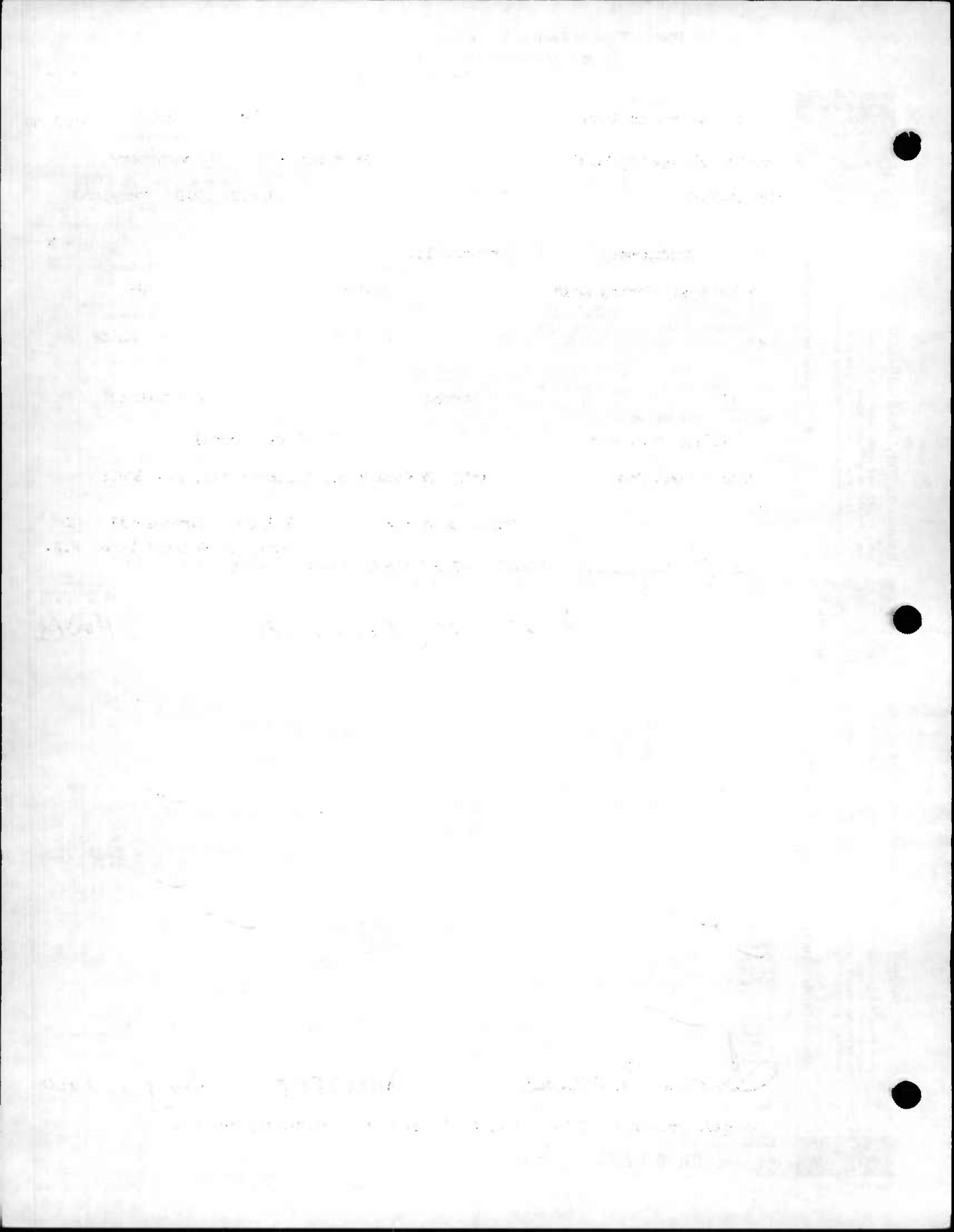
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22131

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy H. Roberts

2. Date of Death

Month Day Year  
6-25-2000

3. Time of Death

10:30PM

4a. Facility Name (If not institution, give street and number)

Graham Nursing Home

4b. City, Town, or Location of Death

Warwick

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

213-24-1696

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
6-19-1910

9. Birthplace (State or Foreign Country)

Delaware

Usual Residence of Decedent

10a. State

Delaware

10b. County

New Castle

10c. City, Town or Location

Odessa

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

P.O. Box 278

10f. Zip Code

19730

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Bank Teller

16b. Kind of Business/Industry

Banking

17. Father's Name (First, Middle, Last)

Joseph C. Hutchison

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Cahoon

19a. Informant's Name/Relationship (Type, Print)

Jeanne Buckworth

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 278 Odessa, De. 19730

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Townsend Cemetery

Date

6-29-00

20c. Location - City or Town, State

Townsend, De.

21. Signature of Funeral Service Licensee

*Robert C. Hutchison Jr.*

22. Name and Address of Facility

Daniels &amp; Hutchison

212 N. Broad St  
Middletown, De.23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

COPD

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimers

Parkinsons dz.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*William Covell*

29c. License number

C1 0005656

29d. Date signed (Month, Day, Year)

6/28/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William Covell

817 N. BROAD ST.

Middletown, De

19709

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

*James B. Sparks*State  
Registrar

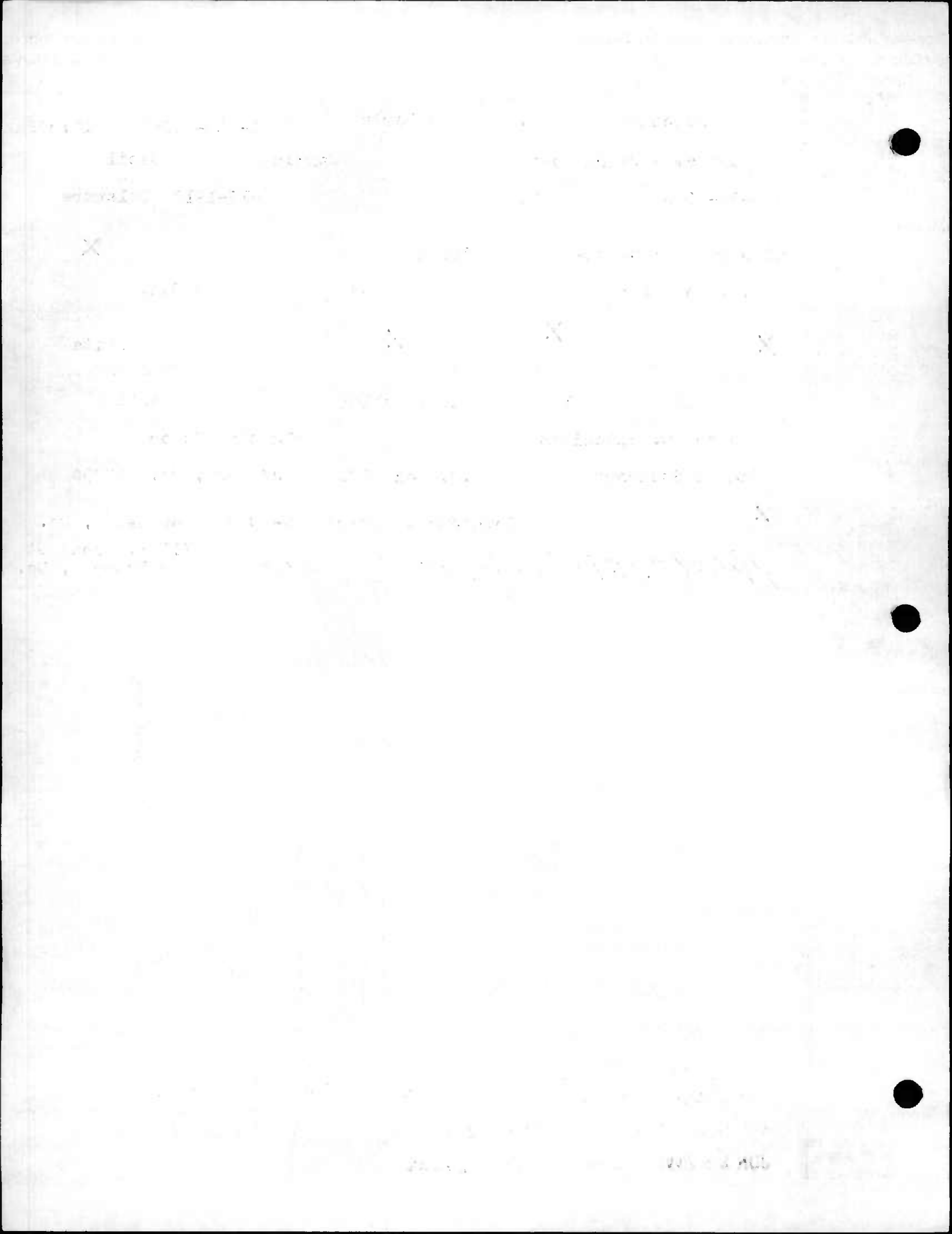
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





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State of Maryland / Department of Health and Mental Hygiene

00 22132

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Grayson Windle Scarff Sr.

2. Date of Death

6 10 2000

3. Time of Death

6:10 PM

4a. Facility Name (If not institution, give street and number)

Manorcare Rossville 6600 Ridge Rd. Baltimore

4b. City, Town, or Location of Death

4c. County of Death

Baltimore

5. Social Security Number

212-32-1620

6. Sex

1 M 2 F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

12/2/1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Harford

10c. City, Town or Location

White Hall

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

4406 Carico Lane

10f. Zip Code

21161

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Walton

Stricker

Scarff

18. Mother's Name (First, Middle, Maiden Surname)

Rosella

Hornberger

19a. Informant's Name/Relationship (Type, Print)

Grayson W. Scarff Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

same as #10 a,b,c,e,f

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Mem. Gardens

Date

6/14

20c. Location - City or Town, State

2000 Bel Air, Maryland

21. Signature of Funeral Service Licensee

M. Blackden Kurtz

22. Name and Address of Facility

E.G. Kurtz & Son Funeral Home, P.A.  
Jarrettsville, Maryland

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

I Ischemic Cardiomyopathy

Approximate Interval Between Onset and Death

3-4 yrs.

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular disease,

Pneumonia, Anemia.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D-38754

29d. Date signed (Month, Day, Year)

06-15-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASSEM,

709. EASTERN BLVD,

MD-21221

31. Date filed (Month, Day, Year)

JUN 20 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Grayson W. Scarff D.O.B. 12-02-07

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10

7/12/2015

15

• • •

2000-01-01 2000-01-01

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22133

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Doris Leona Southerington

2. Date of Death

June 22 2000

3. Time of Death

2245

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

217-20-0268

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Sept. 9, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Joppa

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

408 Gilmore Road

10f. Zip Code

21085

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Henry H. Ruttinger

18. Mother's Name (First, Middle, Maiden Surname)

Doris Leona (UK)

19a. Informant's Name/Relationship (Type, Print)

Henry L. Southerington-son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

408 Gilmore Road, Joppa, Maryland 21085

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lorraine Park Cemetery

Date

June 26, 2000

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Charles A. Emge

22. Name and Address of Facility

McComas Funeral Home, P.A.

1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Peripheral Vascular Disease

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Craig M. Shaughnessy MD

29c. License number

D 37078

29d. Date signed (Month, Day, Year)

June 23, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Craig M. Shaughnessy, 104 Plumtree #115, Bel Air, MD 21015

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22134

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth M. Schussler

2. Date of Death

June 27, 2000

3. Time of Death

7:32 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

218-12-2298

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

06/16/1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7232 German Hill Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Schiefer

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Kvet

19a. Informant's Name/Relationship (Type, Print)

Mr. Charles Schussler/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6 Pierson Court, Bear, Delaware 19701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R.A. Ferris Crematory

Date

7/5/00

20c. Location - City or Town, State

West Chester, PA

21. Signature of Funeral Service Licensee

Christina L. David

Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc., 610 West MacPhail Road, Bel Air, Maryland 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Cardiac Arrest

Due to (or as a consequence of):

c. Pseudomonas Urosepsis

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

24 Hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kunle Berta MD

29c. License number

RD199422

29d. Date signed (Month, Day, Year)

6/27/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Berta Kienle 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

Berta

State Registrar

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22135

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CARRIE STURGIS</b>				2. Date of Death Month Day Year <b>JUNE 15, 2000</b>		3. Time of Death <b>2100</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>220-01-7256</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>7-7-10</b>		9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>WICOMICO</b>		10c. City, Town or Location <b>SALISBURY</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>28475 - OCEAN GATEWAY</b>			10f. Zip Code <b>21804</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LINE WORKER</b>			16b. Kind of Business/Industry <b>CAMPBELL SOUP CO.</b>		
	17. Father's Name (First, Middle, Last) <b>ZEDDICK PURNELL</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ANNIE PURNELL</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>JAMES JONES / SON</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>28475 - OCEAN GATEWAY SALISBURY, MD 21804</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>FRIENDSHIP U.M. CHURCH</b>		Date <b>6/21/2000</b>		20c. Location - City or Town, State <b>ALLEN, MD.</b>	
	21. Signature of Funeral Service Licensee <b>John A. Prince</b>			22. Name and Address of Facility <b>BENNIE SMITH F/H 917 W. ISABELLE ST. SALISBURY, MD. 21801</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive Cardiomyopathy</b> Due to (or as a consequence of): <b>b. Hypertension</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b>							Approximate Interval Between Onset and Death
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure on Dialysis</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
29b. Signature and title of certifier <b>Chahar Nephilopis</b>		29c. License number <b>D-53611</b>		29d. Date signed (Month, Day, Year) <b>6/16/00</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Kazi S. Khan M.D. 547 Riverside Drive Salisbury MD 21801</b>								
State Registrar	31. Date filed (Month, Day, Year) <b>JUN 20 2000</b>		32. Registrar's Signature <b>Geneva B. Smith</b>					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22136

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret Mary Saylor				2. Date of Death Month Day Year June 21, 2000		3. Time of Death 11:45 P.M.	
	4a. Facility Name (If not institution, give street and number) 848 Shore Drive				4b. City, Town, or Location of Death Edgewater		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 579-60-8423	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sep. 20, 1906	9. Birthplace (State or Foreign Country) Washington, DC	
	Usual Residence of Decedent							
10a. State Maryland		10b. County Anne Arundel		10c. City, Town or Location Edgewater		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 848 Shore Drive				10f. Zip Code 21037		10g. Citizen of What Country? USA		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Educator		16b. Kind of Business/Industry D.C. Schools		
17. Father's Name (First, Middle, Last) John W. Koontz				18. Mother's Name (First, Middle, Maiden Surname) Theresa Donovan				
19a. Informant's Name/Relationship (Type, Print) Patricia P. Thacker/ Niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 848 Shore Drive Edgewater, MD 21037				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 6-22-00		20c. Location - City or Town, State Alexandria, Virginia		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. Chronic Obstructive Pulmonary Disease Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death years
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number 741479		29d. Date signed (Month, Day, Year) June 22, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela Calle, M.D. 2448 Holly Avenue, Suite 100, Annapolis, Maryland 21401								
31. Date filed (Month, Day, Year) JUN 27 2000		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1000 S 3 4000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22137

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>James Smothers</b>				2. Date of Death Month Day Year <b>JUNE 18 2000</b>		3. Time of Death <b>5:55 am</b>	
	4a. Facility Name (If not Institution, give street and number) <b>1035 NORMAN DRIVE APT. T7</b>				4b. City, Town, or Location of Death <b>ANNAPOLIS</b>		4c. County of Death <b>ANNE ARUNDEL</b>	
Funeral Director	5. Social Security Number <b>218-26-0350</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>69</b>		8. Date of Birth (Month, Day, Year) <b>AUG. 5 1930</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>ANNAPOLIS</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>1035 NORMAN DRIVE APT. T7</b>		10f. Zip Code <b>21403</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1953</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b>		College (1-4 or 5+) <b>0</b>		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COOK</b>		16b. Kind of Business/Industry <b>US NAVAL ACADEMY</b>		
17. Father's Name (First, Middle, Last) <b>JAMES WESLEY SMOTHERS</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>GRACE DAVIS</b>				
19a. Informant's Name/Relationship (Type, Print) <b>NORMA BRASHEARS (FRIEND)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21403 1035 NORMAN DR. APT. T7 ANNAPOLIS, MD.</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARYLAND VETERAN</b>		Date <b>6/23/00</b>		20c. Location - City or Town, State <b>CROWNSVILLE, MD.</b>		
21. Signature of Funeral Service Licensee <b>Larry S. Reese</b>		22. Name and Address of Facility <b>WM. REESE &amp; SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Prostate Cancer</b>								
23b. Approximate Interval Between Onset and Death <b>9 years</b>								
23c. Immediate Cause (Final disease or condition resulting in death) <b>Due to (or as a consequence of):</b>								
23d. Due to (or as a consequence of):								
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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22138

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gloria Elaine Simpson

2. Date of Death

Month Day Year  
June 23 2000

3. Time of Death

5:30 AM

4a. Facility Name (If not institution, give street and number)

Genesis Eldercare - Spa Creek Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

159-36-6196

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 10, 1944

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

170 Green Street

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Marketing

17. Father's Name (First, Middle, Last)

Joseph Russell

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Nemanis

19a. Informant's Name/Relationship (Type, Print)

Ellen Kallins / Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

170 Green St. Annapolis, MD 21401

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ft. Lincoln Crematory

Date

6-26-00

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

John M. Taylor

22. Name and Address of Facility

John M. Taylor Funeral Home, Inc.  
147 Duke of Gloucester St. Annapolis, MD 2140123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Ovarian Cancer

Approximate  
Interval Between  
Onset and Death

1 yr

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 8 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John M. Taylor

29c. License number

D32036

29d. Date signed (Month, Day, Year)

6/24/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gary J. Sprague 2108 P. Park Drive Chester MD 21619

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

B. Smith

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
0026.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Handwritten text, possibly a signature or date, located in the center of the page.



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State of Maryland / Department of Health and Mental Hygiene

00 22139

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Katherine (NMN) Tanzola				2. Date of Death Month Day Year June 21, 2000		3. Time of Death 1:33 AM	
	4a. Facility Name (If not institution, give street and number) Gilchrist Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 317-03-9279	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Dec. 14, 1919	9. Birthplace (State or Foreign Country) Indiana	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Maryland	10b. County Harford	10c. City, Town or Location Bel Air			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 344 Harlan Street			10f. Zip Code 21014		10g. Citizen of What Country? USA		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Addiction Counselor			16b. Kind of Business/Industry Counseling		
	17. Father's Name (First, Middle, Last) Harry A. Pouder				18. Mother's Name (First, Middle, Maiden Surname) Edna Pouder Potter			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Mary Jo Pons/Friend			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Country Life Estate, POB 107, Bel Air, MD 21014				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Service Corp.		Date 6-26-00		20c. Location - City or Town, State Towson, Maryland	
	21. Signature of Funeral Service Licensee <i>Charles A. Emge</i>			22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Colon cancer</u> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death 3 months
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and Title of certifier <i>W. A. Riley, MD</i>				29c. License number D25205		29d. Date signed (Month, Day, Year) June 21, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley, MD, 6701 N. Charles St. Balt. MD 21204								
31. Date filed (Month, Day, Year) JUN 26 2000		32. Registrar's Signature <i>B. Sparks</i>						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22140

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Francis Oscar Thompson, Jr.

2. Date of Death  
Month Day Year  
June 22 20003. Time of Death  
9:50am

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

219-03-2075

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
11/23/1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

720 Clayton Street

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1941-44

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Francis Oscar Thompson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Liming

19a. Informant's Name/Relationship (Type, Print)

Ruby E. Thompson- Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

720 Clayton St., Aberdeen, MD 21001

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Grdns. 6/26/00

20c. Location - City or Town, State

Bel Air, MD

21. Signature of Funeral Service Licensee

*Dubine M. Smith*

22. Name and Address of Facility

Mitchell-Smith Funeral Home, P.A.  
123 S. Washington, Havre de Grace, MD 21078

23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Acute myocardial infarction*  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*Charles W. Eck*

29c. License number

D 31712

29d. Date signed (Month, Day, Year)

6/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLES ECK JR 219 W. BELT AVE. ABERDEEN, MD 21001

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

*Beau B. Sparks*

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Francis

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

15



1925  
J. L. ...  
...  
...

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State of Maryland / Department of Health and Mental Hygiene 00 22141

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedant's Name (First, Middle, Last) <b>IMO JEAN TROUT</b>			2. Date of Death Month Day Year <b>June 23, 2000</b>		3. Time of Death <b>1:45 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1644 Jerrys Road</b>			4b. City, Town, or Location of Death <b>Street Harford</b>		4c. County of Death <b>Harford</b>	
Funeral Director	5. Social Security Number <b>215-50-7132</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>94</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>2/17/1906</b>
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD.</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Street</b>		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No
	10e. Street and Number <b>1644 Jerrys Road</b>		10f. Zip Code <b>21154</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Caucasian</b>
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>-</b>		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		18b. Kind of Business/Industry <b>Home</b>		
	17. Father's Name (First, Middle, Last) <b>George Washington Hulshart Jr.</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Ida Wirely</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Betty L. Holmes/Daughter</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1314 North Bend Rd. Jarrettsville, Md. 21084</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fawn Grove Cemetery</b>		20c. Location - City or Town, State <b>2000 Fawn Grove, Pa.</b>		
	21. Signature of Funeral Service Licensee <b>M. Blodden Kurtz</b>		22. Name and Address of Facility <b>E.G. Kurtz &amp; Son Funeral Home, P.A. Jarrettsville, Maryland</b>				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. Atherosclerotic Cardiovascular disease</b> Due to (or as a consequence of):						Approximate Interval Between Onset and Death <b>ten years</b>
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
Physician /Medical Examiner	23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown						
	24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred				
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
State Registrar	29b. Signature and title of certifier <b>Mark H Wild MD</b>		29c. License number <b>135522</b>		29d. Date signed (Month, Day, Year) <b>June 26, 2000</b>		
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>MARK WILD 2 NORTH AVENUE BEL AIR MARYLAND 21014</b>						
31. Date filed (Month, Day, Year) <b>JUN 28 2000</b>		32. Registrar's Signature <b>Geneva S. Sparks</b>					

1. 24:1 0007 .000 1.000 1.000 1.000  
2. 24:1 0007 .000 1.000 1.000 1.000  
3. 24:1 0007 .000 1.000 1.000 1.000

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16. 24:1 0007 .000 1.000 1.000 1.000  
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23. 24:1 0007 .000 1.000 1.000 1.000



jhm  
CATHERINE  
THOMPSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22142

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Catherine Proctor Thompson</b>				2. Date of Death Month Day Year <b>JUNE 27, 2000</b>				3. Time of Death <b>14:17 PM</b>					
4a. Facility Name (If not institution, give street and number) <b>2908 PARKLAND DRIVE</b>				4b. City, Town, or Location of Death <b>FORESTVILLE</b>				4c. County of Death <b>PRINCE GEORGES</b>					
5. Social Security Number <b>219-32-4940</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		If Under 1 Year Months Days		If Under 24 Hrs. Hours Min.		8. Date of Birth (Month, Day, Year) <b>July 3, 1923</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
Usual Residence of Decedent													
10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Forestville</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
10e. Street and Number <b>2908 Parkland Drive</b>				10f. Zip Code <b>20747</b>				10g. Citizen of What Country? <b>United States</b>					
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b></b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Her Home</b>					
17. Father's Name (First, Middle, Last) <b>James Albert Proctor</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>							
19a. Informant's Name/Relationship (Type, Print) <b>Catherine Liggins/Niece</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as #10</b>							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Ignatius Church Cemetery</b>				Date <b>July 3, 2000</b>		20c. Location - City or Town, State <b>Port Tobacco, Maryland</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Williams Funeral Home, P.A. 20640 4270 Hawthorne Road, Indian Head, Maryland</b>									
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. HEMOPTYSIS</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>												Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
										24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred					
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier 				29c. License number <b>OCME</b>				29d. Date signed (Month, Day, Year) <b>JUNE 28, 2000</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARYGROVE A. KOREN 111 Penn Street, Baltimore, Maryland 21201</b>													
31. Date filed (Month, Day, Year) <b>JUL 6 3 2000</b>				32. Registrar's Signature 									





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22143

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WYVETTA M. TARBERT

2. Date of Death

Month Day Year  
June 26 2000

3. Time of Death

1022

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

218-40-1468

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

90

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
10/30/1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Whiteford

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1831 Ridge Road

10f. Zip Code

21160

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Simon Beattie

18. Mother's Name (First, Middle, Maiden Surname)

Susanna Hughes

19a. Informant's Name/Relationship (Type, Print)

James O. Tarbert- son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1831 Ridge Rd., Whiteford, MD 21160

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Slateville Cemetery

Date

6/29/00

20c. Location - City or Town, State

Delta, PA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Harkins F.H. Inc., 600 Main St. Delta, PA

17314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ischemic bowel  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

&lt; 2d

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. \_\_\_\_\_  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D32295

29d. Date signed (Month, Day, Year)

June 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David S. Dunn 615 W. MacPha.

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

2003 2 8 MUL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22144

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elise Adela Tramonti

2. Date of Death

Month Day Year  
JUNE 18, 2000

3. Time of Death

6:30 AM

4a. Facility Name (If not institution, give street and number)

SALISBURY CENTER: GENESIS ELDERCARE

4b. City, Town, or Location of Death

SALISBURY, MD

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

217-14-8486

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
7-16-1925

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Wicomico

10c. City, Town or Location

Mardela

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

25049 Ocean Gateway

10f. Zip Code

21837

10g. Citizen of What Country?

USA

11. Marital Status

☐ Navar Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
7

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Beautician

16b. Kind of Business/Industry

Beauty Shop

17. Father's Name (First, Middle, Last)

Gorman Tull

18. Mother's Name (First, Middle, Maiden Surname)

Iva Mae Marsh Tull

19a. Informant's Name/Relationship (Type, Print)

Michael J. Tramonti, Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25049 Ocean Gateway, Mardela, Md. 21837

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Springhill Memory Garden

Date

6-21-00

20c. Location - City or Town, State

Hebron, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Short Funeral Home, Inc.  
13 E. Grove St. Delmar, De. 1994023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. BRAIN TUMOR

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

MONTHS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION  
CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D-29349

29d. Date signed (Month, Day, Year)

6/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

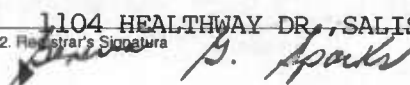
WILLIAM ROBINS, M.D.

1104 HEALTHWAY DR., SALISBURY, Md.

31. Date filed (Month, Day, Year)

JUN 21 2000

32. Registrar's Signature

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22145

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Howard Travers Thompson, Jr.

2. Date of Death

Month Day Year  
JUNE 25 2000

3. Time of Death

1-15 PM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

212-52-4798

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 15, 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severna Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

112 Evergreen Road

10f. Zip Code

21146

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1969-  
If Yes, Give Year or Dates: 197513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)Water  
Electrician /Treatment Operator

16b. Kind of Business/Industry

Water Treatment

17. Father's Name (First, Middle, Last)

Howard T. Thompson, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Jean Adrienne Hurd

19a. Informant's Name/Relationship (Type, Print)

Jean Adrienne Thompson/ mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

112 Evergreen Road, Severna Park, MD 21146

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory, or other place)Zion Evangelical  
Lutheran Church Cemetery

Date

June 28  
2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Barranco & Sons, P.A. Severna Park Funeral Home  
495 Gov. Ritchie Hwy., Severna Park, MD 2114623a. Part I. Enter the disease, or combination that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

ACUTE UPPER GASTRO INTESTINAL BLEEDING

Approximate  
Interval Between  
Onset and Death

1 DAY

Due to (or as a consequence of):

CIRRHOSIS OF LIVER

6 MONTHS

Due to (or as a consequence of):

ALCOHOL ABUSE

20 YEARS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HEPATORENAL SYNDROME

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Yad Shirazi, M.D.

29c. License number

D46962

29d. Date signed (Month, Day, Year)

JUNE 25, 2000.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. SHIRAZI, M.D. NORTH ARUNDEL HOSPITAL. MD 21061.

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

James B. Smith

ORIGINAL

Thompson Jr Howard  
Baltimore, Maryland 21215-0020Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten scribbles and the text "JUN 2 5 000" (likely a date stamp).



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22146

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

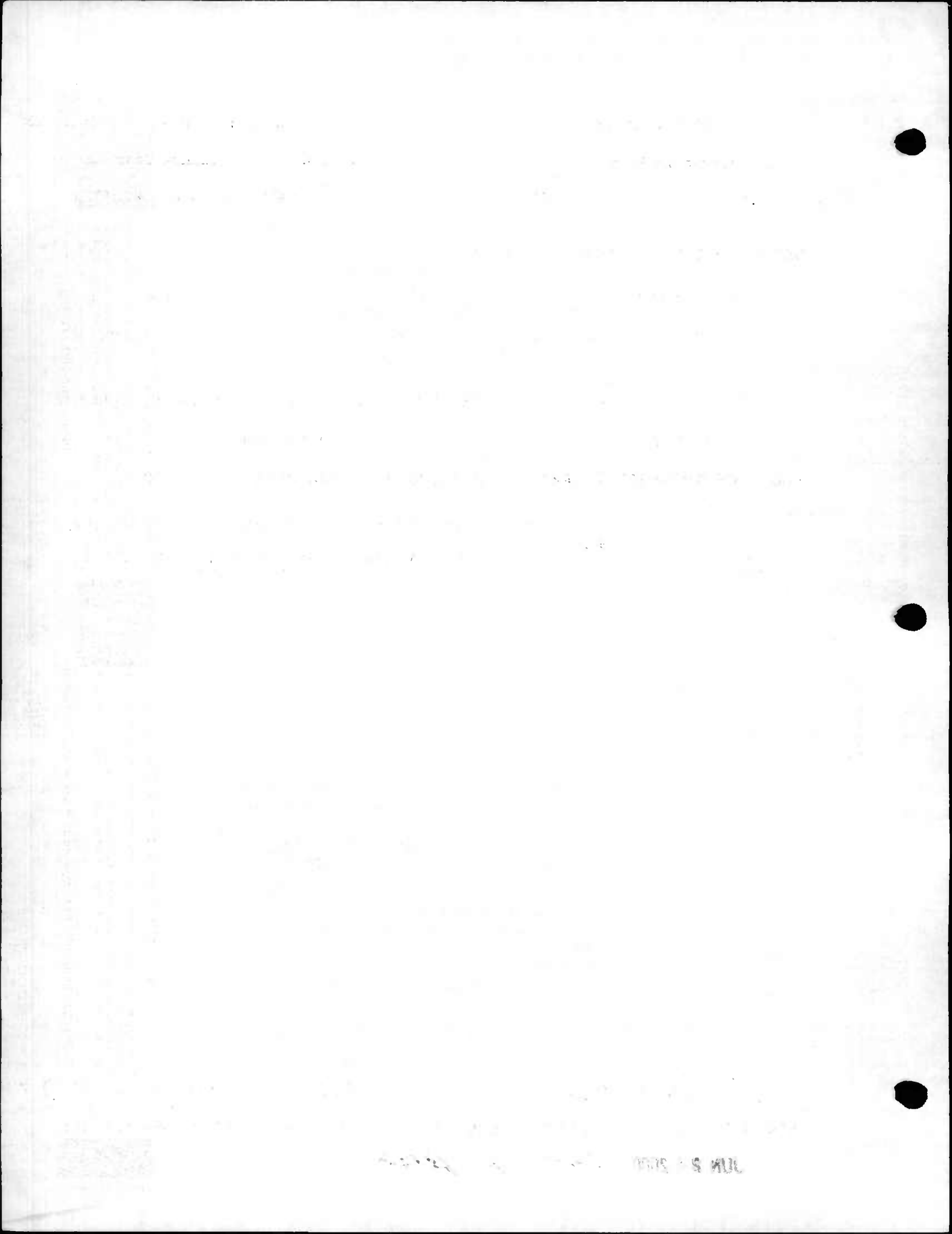
Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>BERT THOMPSON</b>		2. Date of Death Month Day Year <b>June 14, 2000</b>		3. Time of Death <b>10:35 AM</b>	
4a. Facility Name (If not Institution, give street and number) <b>7006 Berkshire Drive</b>		4b. City, Town, or Location of Death <b>Clinton</b>		4c. County of Death <b>Prince Georges</b>	
5. Social Security Number <b>267-07-0013</b>	6. Sex <b>15 M 2 F</b>	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>SEPT. 21 1916</b>
9. Birthplace (State or Foreign Country) <b>FLORIDIA</b>					
10a. State <b>MARYLAND</b>		10b. County <b>ANNE ARUNDEL</b>		10c. City, Town or Location <b>ANNAPOLIS</b>	
10d. Inside City Limits <b>XX Yes 2 No</b>		10e. Street and Number <b>163 ACTON ROAD</b>			
10f. Zip Code <b>21403</b>		10g. Citizen of What Country? <b>USA</b>			
11. Marital Status <b>1 X Married 2 X Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 X Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1 X Yes 2 No</b> Specify: <b>W. W. I I</b>	
14. Race - American Indian, Black, White, etc. <b>Specify: BLACK</b>		15. Decedent's Education (Specify only highest grade completed) <b>12th</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PRESSER LAUNDRY DEPT.</b>		16b. Kind of Business/Industry <b>US NAVAL ACADEMY</b>			
17. Father's Name (First, Middle, Last) <b>REX THOMPSON</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ROSA THOMPSON</b>			
19a. Informant's Name/Relationship (Type, Print) <b>FLORENCE THOMPSON (WIFE)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>163 ACTON RD. ANNAPOLIS, MD. 21403</b>			
20a. Method of Disposition <b>1 X Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		20c. Location - City or Town, State <b>6/26/00 BALTIMORE, MD.</b>	
21. Signature of Funeral Service Licensee <b>Larry H. Reese</b>		22. Name and Address of Facility <b>WM. REESE &amp; SONS MORTUARY, P.A. 8212 WEST ST. ANNAPOLIS, MD. 21401</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. METASTATIC NON SMALL CELL LUNG CANCER</b> Due to (or as a consequence of): <b>b.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b> Due to (or as a consequence of):					Approximate Interval Between Onset and Death <b>3 months</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, DIABETES TYPE 2</b>					23b. Did tobacco use contribute to the cause of death? <b>1 X Yes 2 No 3 Probably 4 Unknown</b>
24a. Was an autopsy performed? <b>1 X Yes 2 No</b>					24b. Were autopsy findings available prior to completion of cause of death? <b>1 X Yes 2 No</b>
25. Was case referred to medical examiner? <b>1 X Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> <b>Daughter's Residence</b>			
27. Manner of Death <b>1 X Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide</b>		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <b>1 X Yes 2 No</b>		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>					
29b. Signature and title of certifier <b>L. H. Reese</b>		29c. License number <b>DC. 21981</b>		29d. Date signed (Month, Day, Year) <b>16 Jun 00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>LLOYD KETCHUM, MD WALTER REED ARMY MEDICAL CENTER, 6900 GEORGIA AVE. WASH., DC</b>					
31. Date filed (Month, Day, Year) <b>JUN 28 2000</b>		32. Registrar's Signature <b>[Signature]</b>			

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22147

amend item 28c per phys. G787 9/1/00 yf

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AURELIO EARL VIVINO

2. Date of Death

Month Day Year  
June 7, 2000

3. Time of Death

6:00 AM

4a. Facility Name (If not institution, give street and number)

10317 Harp Road

4b. City, Town, or Location of Death

Walkersville

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

577-46-9267

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 17, 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Walkersville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10317 Harp Road

10f. Zip Code

21793

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Physician

16b. Kind of Business/Industry

Cardiology

17. Father's Name (First, Middle, Last)

Fred Vivino

18. Mother's Name (First, Middle, Maiden Surname)

Louisa Greco

19a. Informant's Name/Relationship (Type, Print)

Jean Vivino (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10317 Harp Road, Walkersville, Maryland 21793

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

6/8/00

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.  
1201 NORTH MARKET ST., FREDERICK, MD 21701

23a. Part I. Enter the disease or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Stroke

Due to (or as a consequence of):

b.

Alzheimer's Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

1 year

3 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Lerner M.D.

29c. License number

D41619

29d. Date signed (Month, Day, Year)

June 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Lerner, MD 15 East Frederick Street, Walkersville, Maryland 21793

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 08 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22148

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EDWARD LEE VADEN</b>				2. Date of Death Month Day Year <b>JUNE 19, 2000</b>		3. Time of Death <b>2330</b>	
	4a. Facility Name (If not institution, give street and number) <b>PENINSULA REGIONAL MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>SALISBURY</b>		4c. County of Death <b>WICOMICO</b>	
Funeral Director	5. Social Security Number <b>218-32-8513</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>65</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>December 8, 1934</b>	
	9. Birthplace (State or Foreign Country) <b>Virginia</b>		10a. State <b>Maryland</b>		10b. County <b>Baltimore City</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>1927 Eastern Ave</b>		10f. Zip Code <b>21231</b>		10g. Citizen of What Country? <b>USA</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Marines Korea</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Painter</b>		16b. Kind of Business/Industry <b>Painting</b>		17. Father's Name (First, Middle, Last) <b>Lee Baxter Vaden</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Anna Shanks</b>		19a. Informant's Name/Relationship (Type, Print) <b>Shirley A. Pritchett/Sister</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>PO Box 125, Deal Island, MD 21821</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
Physician /Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Salisbury Crematory</b>		20c. Date <b>6/20/00</b>		20d. Location - City or Town, State <b>Salisbury, MD 21804</b>		21. Signature of Funeral Service Licensee <b>David A. Thompson</b>	
	22. Name and Address of Facility <b>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804</b>		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Bacterial Meningitis</b> Due to (or as a consequence of): <b>b. Intracranial Hemorrhage</b> Due to (or as a consequence of): <b>c. Bacteremia</b> Due to (or as a consequence of): <b>d.</b>		Approximate Interval Between Onset and Death <b>Days</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>6/20/00</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>H0054827</b>		29d. Date signed (Month, Day, Year) <b>6/20/00</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MITCHELL BITTELMAN 106 MILFORD ST SALISBURY, MD 21804</b>	
State Registrar	31. Date filed (Month, Day, Year) <b>JUN 21 2000</b>		32. Registrar's Signature <b>[Signature]</b>		33. Date of Death (Month, Day, Year) <b>JUNE 19, 2000</b>		34. Time of Death <b>2330</b>	

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22149

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAWRENCE M. WILLIAMS, Sr.

2. Date of Death

JUNE 30<sup>th</sup> 2000

3. Time of Death

2:00 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

219-22-7602

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 17, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Windsor Mill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6914 Dogwood Rd.

10f. Zip Code

21244

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1945-49 Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Field Engineer

16b. Kind of Business/Industry

Weapons- Guided Systems

17. Father's Name (First, Middle, Last)

Roland Rutledge Williams

18. Mother's Name (First, Middle, Maiden Surname)

Mazie Margaret Staylor

19a. Informant's Name/Relationship (Type, Print)

Sheryl Campson / PR

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6914 Dogwood Rd. Windsor Mill, MD. 21244

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

July 1

2000

20c. Location - City or Town, State

Catonsville, MD.

21. Signature of Funeral Service Licensee

Sherrita Collins - White

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.  
4112 Old Columbia Pike Ellicott City, MD. 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

PNEUMONIA

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

MD

29c. License number

D42723

29d. Date signed (Month, Day, Year)

JUNE 30<sup>th</sup> 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

AVVERARALLI

HARISH

RANDALLSTOWN

MD 21133

31. Date filed (Month, Day, Year)

JUL 05 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22150

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ROY HOBERT WILSON

2. Date of Death

Month Day Year  
JUNE 30 2000

3. Time of Death

7:29 PM

4a. Facility Name (If not institution, give street and number)

SOUTHERN MARYLAND HOSPITAL CENTER

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

218-12-9829

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB 12 1922

9. Birthplace (State or Foreign Country)

Kentucky

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Brandywine

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16204 McKendree Road

10f. Zip Code

20613

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates: WW 11

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

John F. Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Goodin Wilson

19a. Informant's Name/Relationship (Type, Print)

Edmund I. Beyer (step son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11618 Kipling Drive Waldorf, MD 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Trinity Mem. Gardens 7-7-00

Data

20c. Location - City or Town, State

Waldorf, MD

21. Signature of Funeral Service Licensed

MO0173

22. Name and Address of Facility

Eberwein Funeral Service

4433 White Pls La White Pls., MD 20695

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Wks  
2 Wksb. Fournier's gangrene  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary A. dz.

COPD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 8 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D46478

29d. Date signed (Month, Day, Year)

7-1-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh A. Patel MD 7501 Sunnyside Rd # 307 Clinton MD 20735

31. Date filed (Month, Day, Year)

JUL 03 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22151

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WELLINGTON O. WARD, JR.

2. Date of Death

Month Day Year  
JUNE 28 2000

3. Time of Death

2:30 PM

4a. Facility Name (If not institution, give street and number)

SUNRISE CARE FACILITY

4b. City, Town, or Location of Death

ELKTON

4c. County of Death

CECIL

Funeral  
Director

5. Social Security Number

219-42-7994

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

54 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JANUARY 1, 1946

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CECIL

10c. City, Town or Location

ELKTON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

25 MASON COURT

10f. Zip Code

21921

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ELEMENTARY SCHOOL PRINCIPAL

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

WELLINGTON O. WARD, SR.

18. Mother's Name (First, Middle, Maiden Surname)

MARY ANNE LAWSON

19a. Informant's Name/Relationship (Type, Print)

LINDA W. WARD (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25 MASON COURT ELKTON, MD 21921

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

R.A. FERRIS INC.

Date

6/29/00

20c. Location - City or Town, State

WICHESTER, PENNSYLVANIA

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

CEE FUNERAL HOME  
259 E. MAIN ST. ELKTON, MD 21921

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Astrocytoma Brain

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D23322

29d. Date signed (Month, Day, Year)

June 30, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

S. S. SHAHDEV MD, 118 North St Suite 303, Elkton MD 21921.

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

[Signature]

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22152

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLAIRE THELMA WORCH

2. Date of Death

June 27, 2000

3. Time of Death

2:45 p.m.

4a. Facility Name (If not institution, give street and number)

1311 Salonica Place

4b. City, Town, or Location of Death

Bel Air

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

213-26-0987

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

8. Date of Birth

June 2, 1929

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2413 Reckord Road

10f. Zip Code

21047

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles Gais

18. Mother's Name (First, Middle, Maiden Surname)

Clara Wheitert

19a. Informant's Name/Relationship (Type, Print)

Richard H. Worch, Sr. (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2413 Reckord Road, Fallston, MD 21047

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bel Air Memorial Gardens

Date

7/1/00

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

Beverly A. Williams

22. Name and Address of Facility

Schimunek Funeral Home, Inc.  
9705 Belair Road, Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Endometrial Cancer  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

Daughter's residence

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.D.

29c. License number

D 45390

29d. Date signed (Month, Day, Year)

6/29/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MYO MEN (M.D.) 6830 HOSPITAL DR. #206, BALTIMORE, MD 21237

31. Date filed (Month, Day, Year)

JUL 30 2000

32. Registrar's Signature

Beverly A. Williams

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22153

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mavis Waterman</b>				2. Date of Death Month Day Year <b>July 10 2000</b>		3. Time of Death <b>8:26 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Anne Arundel Medical Center</b>				4b. City, Town, or Location of Death <b>Annapolis</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>054 28 3009</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>February 2, 1918</b>	
	9. Birthplace (State or Foreign Country) <b>New Zealand</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Annapolis</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No				10e. Street and Number <b>1004 Sand Piper Lane</b>		10f. Zip Code <b>21403</b>	
	10g. Citizen of What Country? <b>United States</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>0</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>Own Home</b>		17. Father's Name (First, Middle, Last) <b>James Gunn</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Ivy Murch</b>				19a. Informant's Name/Relationship (Type, Print) <b>Paula Gunn Waterman/ Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1004 Sand Piper Lane Annapolis, MD 21403</b>	
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Geo. Wash. University Medical Center</b>		Date <b>July 10 2000</b>		20c. Location - City or Town, State <b>Washington, D.C.</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>dilated cardiomyopathy</b> months Due to (or as a consequence of):  b. <b>coronary artery disease</b> years Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal failure</b> <b>stroke</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier 				29c. License number <b>10023148</b>		29d. Date signed (Month, Day, Year) <b>07/10/2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>James W. Ross, MD 4000 Mitchellville Rd, Bowie, MD 20716</b>							
To Be Completed by Registrar	31. Date filed (Month, Day, Year) <b>JUL 12 2000</b>				32. Registrar's Signature 			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22154

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LINDA MINETTE BRADFORD				2. Date of Death Month Day Year July 11, 2000		3. Time of Death 12:00 pm	
	4a. Facility Name (If not institution, give street and number) Maryland General Hospital				4b. City, Town, or Location of Death Baltimore City		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-54-2272	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 49 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) JUNE 27 1951		9. Birthplace (State or Foreign Country) MARYLAND
	Usual Residence of Decedent							
10a. State MARYLAND		10b. County N/A		10c. City, Town or Location BALTIMORE CITY			10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 47 N. CATHERINE STREET				10f. Zip Code 21223		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: BLACK	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) COOK			16b. Kind of Business/Industry FOOD	
17. Father's Name (First, Middle, Last) SONNY HILL				18. Mother's Name (First, Middle, Maiden Surname) MARY E CARTER				
19a. Informant's Name/Relationship (Type, Print) Mary Johnson/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 752 Linnard Street, Baltimore, Maryland 21229				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Mt ZION CEMETERY		20c. Location - City or Town, State 7-18-00 LANDESDOWN, MARYLAND		
21. Signature of Funeral Service Licensee <i>Charles H. Powell</i>				22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Hemorrhagic Stroke Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier <i>Michael Kelly</i>				29c. License number 89380		29d. Date signed (Month, Day, Year) 7/11/00		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nischal Reddy, M.D. to Maryland General Hospital								
31. Date filed (Month, Day, Year) JUL 13 2000				32. Registrar's Signature <i>Sparks</i>				

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22155

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Verna Mary Brown

2. Date of Death

Month Day Year  
July 11 2000

3. Time of Death

8:15PM

4a. Facility Name (If not institution, give street and number)

Stella Maris

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-16-6274

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 6 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

403 West Timonium Rd.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Administrative Assistant

16b. Kind of Business/Industry

Baltimore City Police

17. Father's Name (First, Middle, Last)

Charles P. Bussman

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Simmons

19a. Informant's Name/Relationship (Type, Print)

Mr. Frank W. Brown/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

403 West Timonium Rd. Timonium, Md. 21093

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) Entombment

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Dulaney Valley Mem Gdns

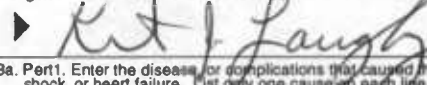
Date

7-15-00

20c. Location - City or Town, State

Timonium, Md.

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Rick Towson Funeral Home, Inc.  
1050 York Rd. Towson, Md. 21204

23a. Pert I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

CANCER OF THE OVARY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D43725

29d. Date signed (Month, Day, Year)

7/12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature



To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 2052A.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JULY 11, 2000 8:15 p.m.

Baltimore, Maryland 21215-0020

VERNA BROWN

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22156

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Duval William Braxton, Junior</u>				2. Date of Death Month <u>July</u> Day <u>5</u> Year <u>2000</u>		3. Time of Death <u>10:41 AM</u>	
	4a. Facility Name (If not institution, give street and number) <u>Johns Hopkins Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore City</u>		4c. County of Death <u>N. A</u>	
Funeral Director	5. Social Security Number <u>579244822</u>	6. Sex <u>M</u> <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>75</u> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <u>3-14-25</u>	9. Birthplace (State or Foreign Country) <u>Pa.</u>	
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <u>MD</u>	10b. County <u>N. A</u>	10c. City, Town or Location <u>Balto</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <u>1401 LAKEWOOD ONE APT 430</u>			10f. Zip Code <u>21213</u>		10g. Citizen of What Country? <u>U.S.A</u>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <u>6/29/43</u> If Yes, Give Year or Dates: <u>2/15/46</u>		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u> College (1-4 or 5+) <u></u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>TRUCK DRIVER</u>		16b. Kind of Business/Industry <u>COMMERCIAL</u>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <u>DUVAL W. BRAXTER</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>LOLLAR STEVENS</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>CHARLOTTE ADAMS</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>1503 ARGONNE DRIVE BALTO. MD 21218</u>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Lawson Forest Cn</u>		20c. Location - City or Town, State <u>7/13/00 Owney Mills Md</u>			
	21. Signature of Funeral Service Licensee <u>Joseph B. Locks Jr</u>		22. Name and Address of Facility <u>Joseph B. Locks Jr 3/4 13047 Central Ave</u>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <u>Sepsis</u> Due to (or as a consequence of): b. <u>Renal Failure</u> Due to (or as a consequence of): c. <u>Diabetes Mellitus</u> Due to (or as a consequence of): d. <u></u>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last						Approximate Interval Between Onset and Death <u>10 days</u> <u>40 days</u> <u>30 years</u>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)			
			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						29b. Signature and title of certifier <u>Jon Keith Sicklick, M.D.</u>	
	29c. License number <u>RES-000</u>						29d. Date signed (Month, Day, Year) <u>July 12, 2000</u>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Jason Keith Sicklick, M.D., Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore, Maryland</u>						21287	
	31. Date filed (Month, Day, Year) <u>JUL 13 2000</u>		32. Registrar's Signature <u>Benjamin B Sparks</u>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





State of Maryland / Department of Health and Mental Hygiene 00 22157

## Reg. No.

DHMH 16 Rev 6/95

12:00

*[Handwritten signature]*

*[Faint handwritten text at the bottom of the page]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22158

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN LEO BUGGLEN

2. Date of Death

Month Day Year  
July 9, 2000

3. Time of Death

5:22 am

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-03-9338

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 10, 1921

9. Birthplace (State or Foreign Country)

Baltimore, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

White Marsh

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5300 Bush Street

10f. Zip Code

21162

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: white15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10 Years

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Brick Layer

16b. Kind of Business/Industry

Bethlehem Steel

17. Father's Name (First, Middle, Last)

Leo Cecil

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Dimler

19a. Informant's Name/Relationship (Type, Print)

Shirley Cave (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5300 Bush Street White Marsh, MD 21162

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

7/11/2000

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

E. F. Lassahn

22. Name and Address of Facility

E.F. Lassahn Funeral Home  
11750 Belair Rd. Kingsville, MD 21087

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive Pulmonary Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic myelogenous Leukemia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kenneth M. McDowell

29c. License number

RD203331

29d. Date signed (Month, Day, Year)

7/9/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR KENNETH MCDOWELL 9000 Franklin Square Drive Baltimore MD 21287

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature

Kenneth M. McDowell

ORIGINAL

Bugglen, John

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1727



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22159

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>EVELYN V. DAY</b>				2. Date of Death Month Day Year <b>JULY 7<sup>TH</sup> 2000</b>		3. Time of Death <b>8:05 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SANDTOWN WINCHESTER NURSING HOME</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>218-10-9311</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>10 21 1916</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore City</b>	
Usual Residence of Decedent		10a. Street and Number <b>1323 N. Calhoun Street</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Private</b>				
17. Father's Name (First, Middle, Last) <b>Harry Day</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mazzie Brown</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Paula D. Thomas/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1323 N. Calhoun Street, Baltimore, Maryland 21217</b>				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt. Zion Cemetery</b>		20c. Location - City or Town, State <b>Landowne, Maryland</b>		20d. Date <b>7/12/00</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>William C. Brown Community Funeral Home 1206 W. North Avenue, Maryland 21217</b>				
23a. Part I - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>RECURRENT PNEUMONIA</b> MONTHS Due to (or as a consequence of):  b. <b>LUNG MASS (BIOPSY PENDING)</b> MONTHS Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CEREBROVASCULAR ACCIDENT</b>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D42510</b>		29d. Date signed (Month, Day, Year) <b>JULY 11<sup>TH</sup>, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. VASANTHA KUMAR, MD 821 N. EUTAW ST # 407, MD 21201</b>								
31. Date filed (Month, Day, Year) <b>JUL 13 2000</b>		32. Registrar's Signature 						

815



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22160

amend item 26 per phys. G785 7/13/00 yg

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LIONEL M. EDWARDS</b>				2. Date of Death Month Day Year <b>JUNE 29, 2000</b>		3. Time of Death <b>6:50 PM</b>		
	4a. Facility Name (If not Institution, give street and number) <b>11714 Reynolds Road</b>				4b. City, Town, or Location of Death <b>Kingsville</b>		4c. County of Death <b>Baltimore</b>		
Funeral Director	5. Social Security Number <b>076-26-8284</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>May 4, 1923</b>		
	9. Birthplace (State or Foreign Country) <b>NY</b>		10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Kingsville</b>		
Usual Residence of Decedent		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>11714 Reynolds Road</b>		10f. Zip Code <b>21087</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>+5</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>college professor</b>		16b. Kind of Business/Industry <b>education</b>		17. Father's Name (First, Middle, Last) <b>Gilbert M. Edwards</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Helene Perillon</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Evelyn Edwards/spouse</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11714 Reynolds Road Kingsville, MD 21087</b>		20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State	
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>		22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>ATHEROSCLEROTIC HEART DISEASE</b>		Approximate Interval Between Onset and Death <b>UNKNOWN</b>			
23a. Part 2. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>HYPERTENSION</b>		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):	
23a. Part 3. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>MULTIPLE SCLEROSIS</b>		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):	
23a. Part 4. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CROHN'S DISEASE</b>		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):		Due to (or as a consequence of):	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MULTIPLE SCLEROSIS</b> <b>CROHN'S DISEASE</b>		23b. Did tobacco use contribute to the causa of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)	
28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <b>Jim Parshall M.D.</b>		29c. License number <b>D4000 8</b>		29d. Date signed (Month, Day, Year) <b>7/5/00</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JIM PARSHALL, 9105 FRANKLIN SQUARE DR., BALTIMORE, MD, 21237</b>		31. Date filed (Month, Day, Year) <b>JUL 13 2000</b>		32. Registrar's Signature <b>Benjamin A. Sparks</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

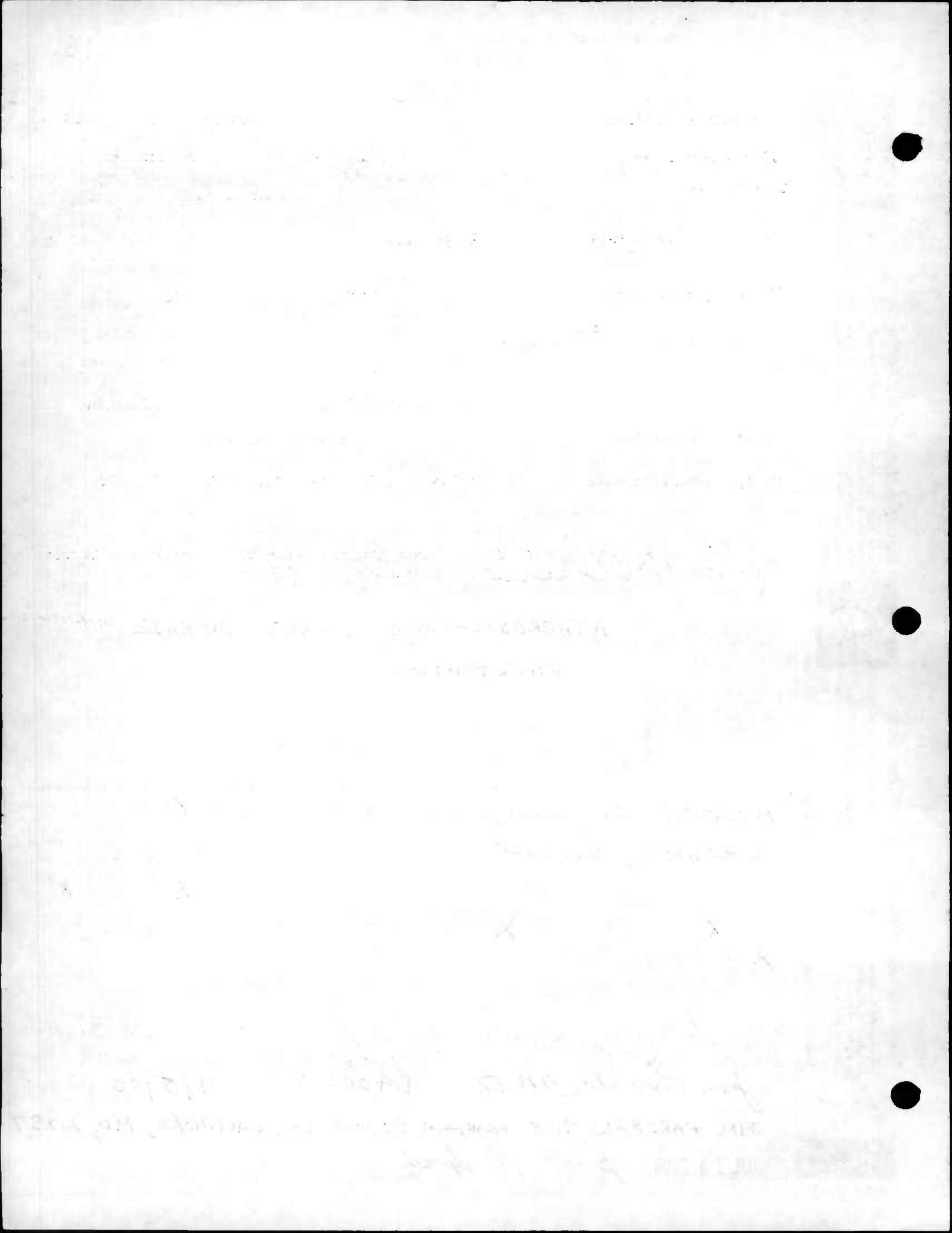
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22161

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine Alieene Fuchs				2. Date of Death Month Day Year JUL 7 2000		3. Time of Death 1602		
	4a. Facility Name (If not institution, give street and number) ST. AGNES HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A		
Funeral Director	5. Social Security Number 215-09-2439		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 90 Yrs.		8. Date of Birth (Month, Day, Year) AUG. 23, 1909		
	9. Birthplace (State or Foreign Country) Maryland		10a. State MD		10b. County Baltimore		10c. City, Town or Location Relay		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 518 Gun Road		10f. Zip Code 21227		10g. Citizen of What Country? USA	
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12		College (1-4 or 5+) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounts Clerk		16b. Kind of Business/Industry Accounting			
17. Father's Name (First, Middle, Last) Henry Fuchs				18. Mother's Name (First, Middle, Maiden Surname) Anna Talbott					
19a. Informant's Name/Relationship (Type, Print) Linda J. Dixon - neice				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 518 Gun Road, Relay, Maryland 21227					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Meadowridge Mem. Park		Data 7/12/00		20c. Location - City or Town, State Elkridge, Md.			
21. Signature of Funeral Service Licensee msk marshall				22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. CARDIAC ARRHYTHMIA Due to (or as a consequence of): b. hypoxia Due to (or as a consequence of): c. Pneumonia Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 5 min 5 days 9 days		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier [Signature]		29c. License number P-13592		29d. Date signed (Month, Day, Year) Jul 7, 2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALEXANDER J. HANSON, MD ST. AGNES HOSPITAL, 900 CATON AVE. 21229				31. Date filed (Month, Day, Year) JUL 13 2000				32. Registrar's Signature [Signature]	

ORIGINAL

1517

WWE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22162

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lionell Grinage

2. Date of Death

Jul 5 2000

3. Time of Death

12:52 AM

4a. Facility Name (If not institution, give street and number)

Bayview Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-42-0442

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

04-11-1945

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

ESSEX

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

815 BRIARHILL PLACE APT B

10f. Zip Code

21221

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

1 Yes 2 No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 Yes 2 No

Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER

16b. Kind of Business/Industry

EXCAVATION CONSTRUCTION

17. Father's Name (First, Middle, Last)

BENJAMIN G GRINAGE

18. Mother's Name (First, Middle, Maiden Surname)

VERA GRINAGE

19a. Informant's Name/Relationship (Type, Print)

Brenda E. Grinage/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

815 Briarhill Place Apt B., Baltimore, Maryland 21221

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

SHARP STREET U.M.C.

Date

7-11-00

20c. Location - City or Town, State

CHASE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

WILLIAM C BROWN COMMUNITY FUNERAL HOME PA

1206 W NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. obesity hypoventilation syndrome

Due to (or as a consequence of):

b. morbid obesity

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

sleep apnea  
congestive heart failure  
respiratory failure

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dary Kaf...

29c. License number

041617

29d. Date signed (Month, Day, Year)

Jul 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Garry Kozlovsk 1805 Hickory Ridge Rd Columbia Md 21044

31. Date filed (Month, Day, Year)

JUL 19 2000

32. Signature of Registrar

Bernice B. Spaw...

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22163

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Ruth Griffith</i>		2. Date of Death Month <i>July</i> Day <i>11</i> Year <i>2000</i>		3. Time of Death <i>8:30 pm</i>
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical Systems</i>		4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>
Funeral Director	5. Social Security Number <i>212-03-9702</i>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <i>88</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <i>May 4, 1912</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>		
Usual Residence of Decedent					
10a. State <i>Maryland</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>Baltimore</i>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <i>1236 Carroll St.</i>		10f. Zip Code <i>21223</i>		10g. Citizen of What Country? <i>U.S.A.</i>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <i>White</i>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i></i>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Sales Clerk</i>		16b. Kind of Business/Industry <i>Sales</i>	
17. Father's Name (First, Middle, Last) <i>George Brown</i>		18. Mother's Name (First, Middle, Maiden Surname) <i>Mary Brown Hartlove</i>			
19a. Informant's Name/Relationship (Type, Print) <i>Dolores Maize, daughter</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1236 Carroll St. Baltimore, MD. 21223</i>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Mount Olivet Cemetery</i>		20c. Location - City or Town, State <i>Baltimore, MD</i>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>Ambrose Funeral Home, Inc. 2119 Hammonds Ferry Rd. Arbutus, MD. 21227</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Brain Aneurysm</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <i>b. </i> Due to (or as a consequence of): <i>c. </i> Due to (or as a consequence of): <i>d. </i>		Approximate Interval Between Onset and Death			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Respiratory Failure</i>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <i></i>		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>44417643512451</i>	
29d. Date signed (Month, Day, Year) <i>July 12, 2000</i>					
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <i>NIRAV SHAH 22 South Greene Street, Baltimore, Maryland 21201</i>					
31. Date filed (Month, Day, Year) <i>JUL 13 2000</i>		32. Registrar's Signature <i>[Signature]</i>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22164

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond Tyson Hatfield

2. Date of Death

Month Day Year  
June 15 2000

3. Time of Death

7:05 PM

4a. Facility Name (If not institution, give street and number)

Deaton Specialty Hospital and Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-09-0520

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 26 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Dayton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4464 Linthicum Road

10f. Zip Code

21036

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
7th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Horse Farm

17. Father's Name (First, Middle, Last)

James T. Hatfield

18. Mother's Name (First, Middle, Maiden Surname)

Mary Mae Woodward

19a. Informant's Name/Relationship (Type, Print)

Nancy Lee Hatfield Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4464 Linthicum Road Dayton, MD 21036

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olive Cemetery

Date

6/19/2000 Mt. Airy, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Burrier-Queen Funeral Directors, P.A.  
1212 W. Old Liberty Road Winfield, MD 21784

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Basal Ganglia Bleed

months

Due to (or as a consequence of):

b. Hemiplegia

months

Due to (or as a consequence of):

c. Sacral Decubitus

month

Due to (or as a consequence of):

d. Diabetes Mellitus

yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred


28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D14571

29d. Date signed (Month, Day, Year)

June 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.T. Folkemer 611 S. Charles ST. Baltimore MD 21230

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22165

AMENDED ITEMS 23a, 27 PER ME G785 7/18/00 AH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROBERT S. HOLTER</b>		2. Date of Death Month <b>July</b> Day <b>06</b> Year <b>2000</b>		3. Time of Death <b>07:35 A.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital</b>		4b. City, Town, or Location of Death <b>Essex</b>		4c. County of Death <b>Baltimore</b>
Funeral Director	5. Social Security Number <b>212-46-3114</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) <b>55</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>Feb. 24, 1945</b>	9. Birthplace (State or Foreign Country) <b>Balto. City, MD</b>
	Usual Residence of Decedent				
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>White marsh</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>11316 Lorley Beach Rd.</b>		10f. Zip Code <b>21162</b>	
10g. Citizen of What Country? <b>USA</b>		11. Mental Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Years</b> College (1-4 or 5+) <b>N/A</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Steel Worker</b>		16b. Kind of Business/Industry <b>Bethlehem Steel Co.</b>		17. Father's Name (First, Middle, Last) <b>William P. Holter Sr.</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Chamberlain</b>		19a. Informant's Name/Relationship (Type, Print) <b>William P. Holter (brother)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>11316 Lorley Beach Rd. White Marsh, MD 21162</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Stephen's church Cemetery</b>		20c. Location - City or Town, State <b>7/10/2000 Kingsville, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>E.F. Lassahn Funeral Home 11750 Belair Rd. Kingsville, MD 21087</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>M</b>		28b. Time of Injury <b>1</b> Yes <input type="checkbox"/> No	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>	
29d. Date signed (Month, Day, Year) <b>July 7, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JACK M. TIMS M.D. 111 Penn Street, Baltimore, Maryland 21201</b>			
31. Date filed (Month, Day, Year) <b>JUL 13 2000</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

A77

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22166

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Florence M. Johnston		2. Date of Death Month Day Year July 11, 2000		3. Time of Death 10:05 A.M.
	4e. Facility Name (If not institution, give street and number) Franklin Square Hospital Center		4b. City, Town, or Location of Death Rosedale		4c. County of Death Baltimore
Funeral Director	5. Social Security Number 213-30-6700	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) January 27, 1915		9. Birthplace (State or Foreign Country) Kansas		
Usual Residence of Decedent					
10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Middle River	
10e. Street and Number 22 Gyro Drive		10f. Zip Code 21220		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: White					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Factory Worker		16b. Kind of Business/Industry Box Factory	
17. Father's Name (First, Middle, Last) Lee Richardson		18. Mother's Name (First, Middle, Maiden Surname) Lily Jackson			
19a. Informant's Name/Relationship (Type, Print) Frances M. Pennell/ Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1416 Kent Rd. Essex, MD 21221			
20e. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory, Inc.		20c. Location - City or Town, State Beltsville, MD	
21. Signature of Funeral Service Licensee Laura C. Hardesty		22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive, Baltimore, MD 21286			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Sepsis Due to (or as a consequence of): b. Peripheral Vascular Disease Due to (or as a consequence of): c. Non-Healing Above Left Knee Amputation Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death 5 Days	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple Cerebrovascular Accident, Anemia, Hypothyroidism, Gastroesophageal Reflux Disease		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29e. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier D. John Sharretts MD		29c. License number D54972		29d. Date signed (Month, Day, Year) 7/11/00	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. John Sharretts 9000 Franklin Square Drive Baltimore, MD 21237					
31. Date filed (Month, Day, Year) JUL 13 2000					
32. Registrar's Signature					

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22167

AMENDED ITEM #23a PER MD G785 7/13/00 AH

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Medora Cora Kromer

2. Date of Death

Month Day Year  
April 20, 2000

3. Time of Death

6:50 am

4a. Facility Name (If not institution, give street and number)

Lorien Nursing Home

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

577-20-8506

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Nov 18, 1923

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10701 Johns Hopkins Road

10f. Zip Code

20723

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Day Care Provider

16b. Kind of Business/Industry

Child Day Care

17. Father's Name (First, Middle, Last)

Purcell Carrick

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Fellgraff

19a. Informant's Name/Relationship (Type, Print)

George W. Kromer /spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10701 Johns Hopkins Road, Laurel, Maryland 20723

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland Veterans Cem

Date

4/25/00

20c. Location - City or Town, State

Cheltenham, Maryland

21. Signature of Funeral Service Licensee

MO0773

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Ave. Laurel, Maryland 20707-4389

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Renal Failure

Due to (or as a consequence of):

DIABETES MELLITUS

b. Due to (or as a consequence of):

HYPERTENSION

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of causa  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D17135

29d. Date signed (Month, Day, Year)

4-20-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Lawrence Swink, MD

9105-A All Saints Road, Laurel, MD 20723

State  
Registrar

31. Date filed (Month, Day, Year)

APR 20 2000

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22168

AMENDED ITEMS 23a, 27 PER ME G785 7/19/00 AH

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) DOUGLAS KEITH LOWE				2. Date of Death Month Day Year JULY 10, 2000				3. Time of Death 21:30 PM			
	4a. Facility Name (If not institution, give street and number) 4116 HAGUE AVENUE				4b. City, Town, or Location of Death BALTIMORE				4c. County of Death BALTIMORE CITY			
Funeral Director	5. Social Security Number 220-62-2252		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 46 Yrs.		8. Date of Birth (Month, Day, Year) MAY 23, 1954		9. Birthplace (State or Foreign Country) MARYLAND			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County BALTIMORE CITY		10c. City, Town or Location BROOKLYN				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 4116 HAGUE AVE.				10f. Zip Code 21230		10g. Citizen of What Country? UNITED STATES					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: '79-'82		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) MACHINIST				16b. Kind of Business/Industry MANUFACTURING			
	17. Father's Name (First, Middle, Last) KEVIN LOWE				18. Mother's Name (First, Middle, Maiden Surname) HELEN PAULINE WILMOUTH							
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) HELEN P. FORNOFF / MOTHER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1637 INVERNESS AVE., BALTIMORE, MD 21230							
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY, INC.		Date JULY 12 2000		20c. Location - City or Town, State CATONSVILLE, MARYLAND					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) SCENE										
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred				
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 				29c. License number OCME		29d. Date signed (Month, Day, Year) JULY 11, 2000				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201												
31. Date filed (Month, Day, Year) JUL 13 2000		32. Registrar's Signature 										

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22169

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hwa Soon Lee

2. Date of Death

Month

Day

Year

7

11

2000

3. Time of Death

0625

4a. Facility Name (If not institution, give street and number)

University of MD

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-64-2411

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN. 1, 1918

9. Birthplace (State or Foreign Country)

North Korea

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7080 Cradle Rock Way, Apt. 612

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Kyung Il Lee

18. Mother's Name (First, Middle, Maiden Surname)

Tae Un Oh

19a. Informant's Name/Relationship (Type, Print)

Christine H. Kelley-Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7216 Downing Ct., Clarksville, Md. 21029

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial Pk.

Date

7/14/00

20c. Location - City or Town, State

Elkridge, Md.

21. Signature of Funeral Service Licensee

M. S. K. Marshall

22. Name and Address of Facility

Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc.  
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Coronary Artery Disease

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wade Gaasch, MD

29c. License number

D37818

29d. Date signed (Month, Day, Year)

7/11/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wade Gaasch

University of Maryland

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

AM





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22170

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Mary Schanze Maione				2. Date of Death Month Day Year July 12, 2000		3. Time of Death 12:50 AM	
	4a. Facility Name (If not institution, give street and number) Gilchrist Hospice				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 220-24-3164		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 84 Yrs.		8. Date of Birth (Month, Day, Year) January 23, 1916	
	Usual Residence of Decedent		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Lutherville	
To Be Completed by Funeral Director	10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Lutherville		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 409 Towson Avenue				10f. Zip Code 21093		10g. Citizen of What Country? United States	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HomeMaker		16b. Kind of Business/Industry Own Home	
	17. Father's Name (First, Middle, Last) Charles Edwin Schanze				18. Mother's Name (First, Middle, Maiden Surname) Alverta List			
	19a. Informant's Name/Relationship (Type, Print) Roland Maione/ Husband				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Towson Avenue Lutherville, MD 21093			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Chesapeake Crematory, Inc.		Date 7/13/00		20c. Location - City or Town, State Beltsville, MD	
	21. Signature of Funeral Service Licensee <i>Laura C. Hardisty</i>				22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286			
	23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>pneumonia</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last							
	23b. Dfd tobacco use contributes to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>pulmonary embolism</u>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <u>Hospice</u>								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <i>W. A. Riley</i>				29c. License number D25205		29d. Date signed (Month, Day, Year) July 12, 2000		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. A. Riley Gilchrist 6801 N. Charles St. Balto. MD 21204								
31. Date filed (Month, Day, Year) JUL 13 2000				32. Registrar's Signature <i>W. A. Riley</i>				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22171

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Peter Nicholas Musico

2. Date of Death

Month Day Year  
July 7th 2000

3. Time of Death

1025AM

4a. Facility Name (If not institution, give street and number)

Harbor Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-84-3905

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN. 28, 1961

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1866 Cedar Drive

10f. Zip Code

21144

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Mason

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Peter Musico

18. Mother's Name (First, Middle, Maiden Surname)

Madeline Eleanor Rake

19a. Informant's Name/Relationship (Type, Print)

Eleanor Spradlin/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

710 Greasy Branch Leander, KY 41228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc.

Date

7/11/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Thomas Gregor

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Road Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiac Arrhythmia 2° Hyperthermia 25 minutes

Due to (or as a consequence of):

b. Respiratory Failure 2° Cerebro Vascular Disease 11 hours

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Sleep Apnea

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician:

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Mohamed Bakleh MD

29c. License number

RES000

29d. Date signed (Month, Day, Year)

July 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohamed Bakleh, MD 3001 S. Hanover Street, Baltimore, MD 21225

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature

Benita S. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22172

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LEON CLAIR PERRY M.D.				2. Date of Death Month Day Year JULY 10, 2000		3. Time of Death 9:30 AM	
	4a. Facility Name (If not institution, give street and number) 2700 SUMMERVIEW WAY APT. 204				4b. City, Town, or Location of Death ANNAPOLIS		4c. County of Death ANNE ARUNDEL	
Funeral Director	5. Social Security Number 236-24-6932	6. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>	7. Age (In yrs. last birthday) 79 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) MARCH 16, 1921		9. Birthplace (State or Foreign Country) W. VIRGINIA
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location ANNAPOLIS		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 2700 SUMMERVIEW WAY APT. 204				10f. Zip Code 21401		10g. Citizen of What Country? UNITED STATES	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1942-1945		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PHYSICIAN		16b. Kind of Business/Industry HEALTH CARE			
	17. Father's Name (First, Middle, Last) ANDY PERRY				18. Mother's Name (First, Middle, Maiden Surname) MERLE WOODS			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) MRS. JEANNE PERRY/WIFE				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2700 SUMMERVIEW WAY APT. 204 ANNAPOLIS, MD 21401			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) METRO CREMATORY		Date JULY 11, 2000		20c. Location - City or Town, State CATONSVILLE, MD	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility KIRKLEY-RODDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Myocardial Infarction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Atrial Fibrillation Cardiomyopathy				Approximate Interval Between Onset and Death Minutes			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Atrial Fibrillation Cardiomyopathy				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
			28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number D15860		29d. Date signed (Month, Day, Year) JULY 10, 2000	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HILARY T. O'HERLIHY M.D. 325 HOSPITAL DRIVE GLEN BURNIE, MD 21061 SUITE 208							
State Registrar	31. Date filed (Month, Day, Year) JUL 13 2000		32. Registrar's Signature <i>[Signature]</i>					

ORIGINAL



2151

11-17-1944

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22173

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pessy Poplin

2. Date of Death

Month Day Year  
July 11 2000

3. Time of Death

641 AM

4a. Facility Name (If not institution, give street and number)

Harbor Hospital Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-40-7617

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT 3, 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Brooklyn Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

264 Rupert Circle

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Store Clerk

16b. Kind of Business/Industry

Discount Dept. Store

17. Father's Name (First, Middle, Last)

Charles W. Hensler

18. Mother's Name (First, Middle, Maiden Surname)

Katie Galloway

19a. Informant's Name/Relationship (Type, Print)

Charles E. Hensler / brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

262 Rupert Circle Brooklyn Park, MD 21225

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc.

Date

07/12/00

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

George E. MacNabb

22. Name and Address of Facility

Cremation Society of MD, Inc.  
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. metastatic right pleural effusion

2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. metastatic breast cancer of right breast

2 years

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

cellulitis of right chest wall

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Peter Craig, MD

29c. License number

res001

29d. Date signed (Month, Day, Year)

July 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter Craig, MD 3001 South Harrow Street, Baltimore, Maryland 21225

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature

Peter B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1911

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22174

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

David A Provencher

2. Date of Death

Month Day Year  
July 9 2000

3. Time of Death

7:56 pm

4a. Facility Name (If not Institution, give street and number)

HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral  
Director

5. Social Security Number

030-32-8550

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
APR 29, 1943

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

9214 Tunemaker Terrace

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Aged Forc? 1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1960-64

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Director Of Sales

16b. Kind of Business/Industry

Security Equipment

17. Father's Name (First, Middle, Last)

Arthur Provencher

18. Mother's Name (First, Middle, Maiden Surname)

Lorraine Dumas

19a. Informant's Name/Relationship (Type, Print)

Deborah A. Provencher/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9214 Tunemaker Terrace Columbia, Md. 21045

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 7/12/00 Baltimore, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Thomas Gregor

22. Name and Address of Facility

Cremation Society Of Md. Inc.

299 Frederick Road Baltimore, Md. 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC Lung Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Nicholas J. Provencher

29c. License number

D38504

29d. Date signed (Month, Day, Year)

July 16 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nicholas J. Provencher 11065 Little Patuxent Pkwy Columbia MD 21044

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature

Benita B. Spawls

State  
Registrar

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 22175

Reg. No.

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1441  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>Christopher Scott Stark</b>		2. Date of Death Month <b>July</b> Day <b>11</b> Year <b>2000</b>		3. Time of Death <b>550 am</b>	
4a. Facility Name (If not institution, give street and number) <b>1101 North Toll Gate Road</b>		4b. City, Town, or Location of Death <b>Bel Air</b>		4c. County of Death <b>Harford</b>	
5. Social Security Number <b>205-44-3391</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>32</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>July 2, 1968</b>		9. Birthplace (State or Foreign Country) <b>Pa.</b>			
Usual Residence of Decedent					
10a. State <b>Md.</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Bel Air</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1101 North Toll Gate Road</b>		10f. Zip Code <b>21014</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 yrs.</b> College (1-4 or 5+) <b>4 yrs.</b>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Sales</b>		16b. Kind of Business/Industry <b>Pool Supply</b>		17. Father's Name (First, Middle, Last) <b>Greg Stark</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>Anita Stark</b>		19a. Informant's Name/Relationship (Type, Print) <b>Sharon Beazley mother-in-law</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1910 August Ave. Dundalk Md. 21222</b>	
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Location - City or Town, State <b>Baltimore</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Intraoral Shotgun Wound</b>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DSA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>7/11/00</b>		28b. Time of Injury (Hour, Minute) <b>0400</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Subject Shot Self</b>		28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>Bel Air, Md</b>	
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and Title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>July 11, 2000</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>					
31. Date filed (Month, Day, Year) <b>JUL 13 2000</b>		32. Registrar's Signature 			





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State of Maryland / Department of Health and Mental Hygiene

00 22176

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) LONETTA O. STINCHCOMB				2. Date of Death Month Day Year JULY 9, 2000		3. Time of Death 5:30 A.M.		
	4a. Facility Name (If not institution, give street and number) CROFTON CONVALESCENT CENTER				4b. City, Town, or Location of Death CROFTON		4c. County of Death ANNE ARUNDEL		
Funeral Director	5. Social Security Number 213-22-0732	6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) OCT. 2, 1907		9. Birthplace (State or Foreign Country) MARYLAND	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State MARYLAND	10b. County ANNE ARUNDEL	10c. City, Town or Location SEVERN			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	10e. Street and Number 1231 OLD CAMP MEADE RD.			10f. Zip Code 21144		10g. Citizen of What Country? UNITED STATES			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: WHITE		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOSPITAL WORKER			16b. Kind of Business/Industry MEDICAL			
	17. Father's Name (First, Middle, Last) THOMAS UPTON				18. Mother's Name (First, Middle, Maiden Surname) INEZ WATTS				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) STANLEY H. STINCHCOMB/ SON				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1229 OLD CAMP MEADE RD., SEVERN, MARYLAND 21144				
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEM. PARK		Data JULY 12 2000		20c. Location - City or Town, State GLEN BURNIE, MARYLAND		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061				
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Atherosclerosis</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Dysphagia, Hypertension</u>						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier M.D.		29c. License number D38958		29d. Date signed (Month, Day, Year) JULY 10, 2000			
30. Address of decedent on date of death (Item 23a) (Type, Print) 1413 ANNAPOLIS RD., #106, ODENTON, MARYLAND 21113									
State Registrar	31. Date filed (Month, Day, Year) JUL 13 2000		32. Registrar's Signature 						

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22177

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jack Starr

2. Date of Death

Month

Day

Year

July 9, 2000

3. Time of Death

6:32 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6406 Golden Ring Road

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

572-46-1396

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUL 19, 1928

9. Birthplace (State or Foreign Country)

England

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6406 Golden Ring Road

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1953-56

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electrician

16b. Kind of Business/Industry

Communications

17. Father's Name (First, Middle, Last)

Cyril Starr

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Ash

19a. Informant's Name/Relationship (Type, Print)

Elizabeth L. Starr/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6406 Golden Ring Road Rosedale, MD 21237

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 7/10/00 Baltimore, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of MD, Inc.  
299 Frederick Road Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic hypertension  
Peripheral vascular disease  
Bladder Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D35305

29d. Date signed (Month, Day, Year)

July 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Hsiao, M.D. 5601 Loch Raven Blvd. Baltimore, MD 21239

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22178

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Donald James Simmons					2. Date of Death Month Day Year July 12, 2000		3. Time of Death 12:45 AM			
	4a. Facility Name (If not institution, give street and number) Oak Crest Village Care Center					4b. City, Town, or Location of Death Parkville		4c. County of Death Baltimore			
Funeral Director	5. Social Security Number 216-10-0240		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) FEB 17, 1909		9. Birthplace (State or Foreign Country) Maryland		
	Usual Residence of Decedent										
10a. State Maryland			10b. County Baltimore			10c. City, Town or Location Parkville			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. Street and Number 8832 Walther Boulevard					10f. Zip Code 21234		10g. Citizen of What Country? USA				
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Chief Electrician			16b. Kind of Business/Industry Military Sealift Command			
17. Father's Name (First, Middle, Last) Richard Franklin Simmons					18. Mother's Name (First, Middle, Maiden Surname) Margaret Donighan						
19a. Informant's Name/Relationship (Type, Print) Joyce Pflum/Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 Hillsmere Drive Annapolis, MD 21403						
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.			Date 7/12/00		20c. Location - City or Town, State Baltimore, MD			
21. Signature of Funeral Service Licensee Edward A. Gregorchik					22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 21228						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. END STAGE DEMENTIA Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death yrs.											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure/severe anemia Chronic hematuria/osteoporosis											
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier Kendall R Faulkner					29c. License number D25643			29d. Date signed (Month, Day, Year) 07/12/2000			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K R Faulkner MD/8800 Walther Blvd/Baltimore MD 21234											
31. Date filed (Month, Day, Year) JUL 13 2000			32. Registrar's Signature Sparks								





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22179

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Arthur E. Vail, Sr.				2. Date of Death Month Day Year July 10 2000		3. Time of Death 7:07 AM	
	4a. Facility Name (If not institution, give street and number) St. Agnes Hospital				4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A	
Funeral Director	5. Social Security Number 218-22-3313		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 74 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 15, 1926	
	10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Funeral Director	10e. Street and Number 1112 Plover Drive				10f. Zip Code 21227		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1946		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Electrician		16b. Kind of Business/Industry Electrical	
	17. Father's Name (First, Middle, Last) Phillip T. Vail				18. Mother's Name (First, Middle, Maiden Surname) Susie Harrell			
	19a. Informant's Name/Relationship (Type, Print) Shirley L. Vail, wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1112 Plover Drive, Arbutus, MD. 21227			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Loudon Park Cemetery		Date 7-12-00		20c. Location - City or Town, State Baltimore, MD	
	21. Signature of Funeral Service Licensee <i>Nick Daugherty</i>				22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. MYOCARDIAL INFARCTION Due to (or as a consequence of): b. CARDIAC PACEMAKER Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Chad C. [unclear]</i>		29c. License number D0051865	
	29d. Date signed (Month, Day, Year) JULY 10, 2000							
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTOS CURTIS ST AGNES HOSPITAL, BALTIMORE							
31. Date filed (Month, Day, Year) JUL 13 2000		32. Registrar's Signature <i>[Signature]</i>						

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 22180

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Lois Wilson</i>				2. Date of Death Month <i>July</i> Day <i>10</i> Year <i>2000</i>		3. Time of Death <i>1:59 AM</i>			
	4a. Facility Name (If not institution, give street and number) <i>University of Maryland Medical System</i>				4b. City, Town, or Location of Death <i>Baltimore</i>		4c. County of Death <i>N/A</i>			
Funeral Director	5. Social Security Number <i>228-68-1314</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>56</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>10-3-1943</i>			
	10a. State <i>MD.</i>		10b. County <i>N/A</i>		10c. City, Town or Location <i>BALTIMORE</i>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>BLACK</i>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>-10-</i> College (1-4 or 5+) <i>-0-</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>MANAGER</i>		16b. Kind of Business/Industry <i>DEPARTMENT STORE</i>				
17. Father's Name (First, Middle, Last) <i>ROBERT WINDLEY</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>ELSIE P. BAILEY</i>						
19a. Informant's Name/Relationship (Type, Print) <i>CHARLES WILSON (HUSBAND)</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3910 THE ALAMEDA BALTIMORE, MARYLAND 21218</i>						
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>WOODLAWN CEMETERY</i>		Date <i>7-15-2000</i>		20c. Location - City or Town, State <i>BALTIMORE, MARYLAND</i>		
21. Signature of Funeral Service Licensee <i>Janeth O. Huzar</i>				22. Name and Address of Facility <i>PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217</i>						
Physician /Medical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <i>a. Necrotizing Soft tissue infection</i> Due to (or as a consequence of): <i>b. Multisystem Failure</i> Due to (or as a consequence of): <i>c.</i> Due to (or as a consequence of): <i>d.</i>							Approximate Interval Between Onset and Death <i>~23 DAYS</i>		
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. Date of injury (Month, Day Year)							28b. Time of injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
28d. Describe how injury occurred							28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							29b. Signature and title of certifier <i>Kerry Kole D.O.</i>		29c. License number <i>H55103</i>	
29d. Date signed (Month, Day, Year) <i>July 11, 2000</i>							30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Kerry Kole MD 22 Smith Greene Street Baltimore, Maryland 21201</i>			
31. Date filed (Month, Day, Year) <i>JUL 13 2000</i>							32. Registrar's Signature <i>[Signature]</i>			

ORIGINAL

Franklin D. Roosevelt

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State of Maryland / Department of Health and Mental Hygiene

00 22181

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Garfield Wright

2. Date of Death

Month  
JulyDay  
11Year  
2000

3. Time of Death

16:34 pm

4a. Facility Name (If not institution, give street and number)

Union Mem. Hosp.

4b. City, Town, or Location of Death

Balto.

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

230-34-4754

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-15-1930

9. Birthplace (State or Foreign Country)

Va.

Usual Residence of Decedent

10a. State

Md

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1115 Bonaparte Ave

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
5th gradeCollege (1-4 or 5+)  
n/a16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Labor

16b. Kind of Business/Industry

Beth. Steel

17. Father's Name (First, Middle, Last)

Henry Wright

18. Mother's Name (First, Middle, Maiden Surname)

Sallie Abstin

19a. Informant's Name/Relationship (Type, Print)

Silvia Wright

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1115 Bonaparte Ave. Balto. Md. 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Arbutus Mem.

Date

7/15/2000

20c. Location - City or Town, State

Arbutus Md.

21. Signature of Funeral Service Licensee

Patricia B...

22. Name and Address of Facility

Beths Funeral Home 21213  
1129 N. Caroline St. Balto. Md23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Respiratory Failure  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

24 hours

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Small cell Lung cancer  
Due to (or as a consequence of):

14 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

CHUN HONG, Chunhongmo

29c. License number

AT2438946

29d. Date signed (Month, Day, Year)

July, 11<sup>th</sup>, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chun Hong, Union Memorial Hosp. Baltimore MD 21218.

31. Date filed (Month, Day, Year)

JUL 13 2000

Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
800-552-2828.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

w j

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22182

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EMMITT

2. Date of Death

Month

Day

Year

3. Time of Death

7:30 p.m.

4a. Facility Name (If not institution, give street and number)

John Secler Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

217-566747

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Month, Day, Year

December 24, 1950

9. Birthplace (State or Foreign Country)

GH

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1505 W. McHenry St

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (13-16)

College (17-49)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Home Improvement

17. Father's Name (First, Middle, Last)

Emmitt Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Ivett Lewis

19a. Informant's Name/Relationship (Type, Print)

Valerie James friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1505 McHenry St. Balt. MD 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt Zion Cemetery 7/15/00 Lansdowne, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Wylee Funeral Hse. 21217 688 N. Belmor St. Balt. MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Pneumocystis carinii pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Acquired Immunodeficiency Syndrome

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis  
End stage Renal Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0016263

29d. Date signed (Month, Day, Year)

July 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUAN X. BELTRAN 1940 W. BALT ST, BALT, MD 21223

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature

[Signature]

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, MD 21206

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22183

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John L. Wetters

2. Date of Death

July 12 2000

3. Time of Death

1:32 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

218-30-6592

6. Sex

100 M 20 F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

08/31/1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Middle River

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

136 Trailway RD

10f. Zip Code

21220

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

10 Yes 20 No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
10 Yes 20 No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Lithographing

16b. Kind of Business/Industry

Baltimore Sun Newspaper

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Summa)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Rosemary Maszon Sister-in-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

140 Rodeo Drive Middle River, MD 21220

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Balto.-Wash. Crematory

Date

07/14

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bradley Ashton Matthews Funeral Home, Inc.  
2134 Willow Spring RD Baltimore, MD 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Sepsis

Due to (or as a consequence of):

b.

Acute myocardial Infarction

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

10 Days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy  
performed?

10 Yes 20 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

10 Yes 20 No

25. Was case referred to medical  
examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending  
20 Accident investigation  
30 Suicide 60 Could not be  
40 Homicide determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

10 Yes 20 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

10 Certifying Physician

20 Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Sanju Varghese M.D.

29c. License number

RD 203323

29d. Date signed (Month, Day, Year)

7/12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Sanju Varghese 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature

Geneva B Sparks

State  
RegistrarWETTERS John  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPermit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22184

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) HELEN M. WOOD						2. Date of Death Month Day Year JULY 11 2000		3. Time of Death 11:30 PM																																		
	4a. Facility Name (If not institution, give street and number) 8311 ELVATON ROAD						4b. City, Town, or Location of Death MILLERSVILLE		4c. County of Death ANNE ARUNDEL																																		
Funeral Director	5. Social Security Number 215-03-5739		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 86 Yrs.		8. Date of Birth (Month, Day, Year) NOV. 28, 1913		9. Birthplace (State or Foreign Country) MARYLAND																																		
	Usual Residence of Decedent																																										
10a. State MARYLAND		10b. County ANNE ARUNDEL		10c. City, Town or Location MILLERSVILLE				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																			
10e. Street and Number 8311 ELVATON ROAD						10f. Zip Code 21108		10g. Citizen of What Country? UNITED STATES																																			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE																																				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) HOMEMAKER			16b. Kind of Business/Industry OWN HOME																																				
17. Father's Name (First, Middle, Last) PAULUS WAJTOWICZ						18. Mother's Name (First, Middle, Maiden Surname) ANNA RUDNICKA																																					
19a. Informant's Name/Relationship (Type, Print) DAVID J. WOOD / SON						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8297 ELVATON RD. MILLERSVILLE, MD 21108																																					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) GLEN HAVEN MEM. PK. 2000			20c. Location - City or Town, State GLEN BURNIE, MD																																				
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061																																							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																											
<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td colspan="7">Congestive Heart Failure</td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b.</td> <td colspan="7">Chronic OBSTRUCTIVE PULMONARY DISEASE</td> </tr> <tr> <td>c.</td> <td colspan="7"></td> </tr> <tr> <td>d.</td> <td colspan="7"></td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)	a.	Congestive Heart Failure							Approximate Interval Between Onset and Death	b.	Chronic OBSTRUCTIVE PULMONARY DISEASE							c.								d.							
Immediate Cause (Final disease or condition resulting in death)	a.	Congestive Heart Failure							Approximate Interval Between Onset and Death																																		
	b.	Chronic OBSTRUCTIVE PULMONARY DISEASE																																									
	c.																																										
	d.																																										
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																																											
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																											
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																											
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																																			
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																																					
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																																											
29b. Signature and title of certifier 				29c. License number D20094		29d. Date signed (Month, Day, Year) JULY 13, 2000																																					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELLIOTT GORBATY, M.D. 7845 OAKWOOD RD. GLEN BURNIE, MD 21061																																											
31. Date filed (Month, Day, Year) JUL 13 2000				32. Registrar's Signature 																																							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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amend item 26 per phys. G785 7/13/00  
AMENDED ITEM #26 PER MD G785 7/13/00 AH

Certificate of Death

Reg. No.

00 22185

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Ronald Wilson</u>		2. Date of Death Month <u>June</u> Day <u>29</u> Year <u>2000</u>		3. Time of Death <u>5:55 PM</u>
	4a. Facility Name (If not institution, give street and number) <u>Harbor Hospital Center</u>		4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>
Funeral Director	5. Social Security Number <u>UNKNOWN</u>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>55</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <u>MAY 12, 1945</u>		9. Birthplace (State or Foreign Country) <u>OHIO</u>		
Usual Residence of Decedent					
10a. State <u>MARYLAND</u>		10b. County <u>A. A. COUNTY</u>		10c. City, Town or Location <u>GLEN BURNIE</u>	
10d. Inade City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <u>5 WARFIELD ROAD</u>		10f. Zip Code <u>21061</u>	
10g. Citizen of What Country? <u>USA.</u>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>BLACK</u>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10TH GRADE</u> College (1-4 or 5+) <u>CONSTRUCTION WORKER CONSTRUCTION COMPANY</u>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry		17. Father's Name (First, Middle, Last) <u>ARTHUR WILSON</u>	
18. Mother's Name (First, Middle, Maiden Surname) <u>LAURA JONES</u>		19a. Informant's Name/Relationship (Type, Print) <u>MINNIE BROWN (SISTER)</u>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>710 DEACON HILL COURT BALTIMORE MD. 21225</u>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>CEDAR HILL CEMETERY</u>		20c. Location - City or Town, State <u>07-06-00 GLEN BURNIE, MD.</u>	
21. Signature of Funeral Service Licensee <u>[Signature]</u>		22. Name and Address of Facility <u>JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTO. MD. 21217</u>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <u>Prostate Cancer</u>		Approximate Interval Between Onset and Death <u>5 year</u>	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b. <u>Metastatic prostate cancer to liver</u>		<u>5 year</u>	
		c. Due to (or as a consequence of):			
		d. Due to (or as a consequence of):			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Stroke</u>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DCA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <u>Daniel Kohn MD</u>		29c. License number <u>D 19439</u>		29d. Date signed (Month, Day, Year) <u>June 29, 2000</u>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u>Daniel Kohn MD 30015 Hanover Street Baltimore, Maryland 21225</u>					
31. Date filed (Month, Day, Year) <u>JUL 13 2000</u>		32. Registrar's Signature <u>[Signature]</u>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 22186

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>OLGA WISE</b>				2. Date of Death Month <b>JULY</b> Day <b>1</b> Year <b>2000</b>				3. Time of Death <b>0126</b>	
	4a. Facility Name (If not institution, give street and number) <b>The Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>				4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>033-30-5122</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (in yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept 5, 1923</b>		9. Birthplace (State or Foreign Country) <b>Poland</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>3407 W. Rogers Avenue</b>				10f. Zip Code <b>21215</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>telephone operator</b>				16b. Kind of Business/Industry <b>communications</b>		
17. Father's Name (First, Middle, Last) <b>Gottlieb Finger</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hilda Dombrowski</b>						
19a. Informant's Name/Relationship (Type, Print) <b>Fleetwood Wise/spouse</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3407 W. Rogers Avenue Baltimore, MD 21215</b>						
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>				20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State				
21. Signature of Funeral Service Licensee <b>Ronald S. Wade, Director</b>				22. Name and Address of Facility <b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. MYOCARDIAL INFARCTION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				Approximate Interval Between Onset and Death <b>30 MINUTES</b>						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
								24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number <b>RES-000</b>				29d. Date signed (Month, Day, Year) <b>JULY 1, 2000</b>		
29b. Signature and title of certifier <b>ALAN CHENG MEDICAL HOUSESTAFF</b>										
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ALAN CHENG 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND 21209</b>										
31. Date filed (Month, Day, Year) <b>JUL 13 2000</b>				32. Registrar's Signature <b>Benjamin S. Sparks</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22187

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SYBIL C. WALTERS

2. Date of Death

Month Day Year  
July 06 2000

3. Time of Death

1:20 a.m.

4a. Facility Name (If not institution, give street and number)

Mariner Health-BelAir

4b. City, Town, or Location of Death

BelAir

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

238-12-9976

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 11, 1919

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

Harford

10c. City, Town or Location

Kingsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

716 Karen Drive

10f. Zip Code

21087

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 years

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Hair Dresser

16b. Kind of Business/Industry

Beauty Salon

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Cannedy

19a. Informant's Name/Relationship (Type, Print)

Frederick Z. Walters (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

716 Karen Drive Kingsville, Md 21087

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) entombment20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dulaney Valley Mausoleum

Date

7/8/2000

20c. Location - City or Town, State

Timonium, Balto County, MD

21. Signature of Funeral Service Licensee

E.F. Lassahn

22. Name and Address of Facility

E.F. Lassahn Funeral Home  
11750 Belair Rd. Kingsville, MD 2108723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

1 month

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Scott Haswell MD

29c. License number

D34652

29d. Date signed (Month, Day, Year)

July 6, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Scott Haswell 2 North Avenue Bel Air Maryland 21014

31. Date filed (Month, Day, Year)

JUL 13 2000

32. Registrar's Signature

James P. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 22188

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Raymond James Westberg				2. Date of Death Month Day Year JULY 9, 2000		3. Time of Death 2138 PM								
	4a. Facility Name (If not institution, give street and number) 3933 COLCHESTER ROAD				4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death								
Funeral Director	5. Social Security Number 218.96.3051		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 34 Yrs.		8. Date of Birth (Month, Day, Year) 09.10.1965		9. Birthplace (State or Foreign Country) Bethesda, MD						
	Usual Residence of Decedent														
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore				10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
10e. Street and Number 3933 Colchester Rd.				10f. Zip Code 21229		10g. Citizen of What Country? USA									
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White							
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Carpenter			16b. Kind of Business/Industry Trade								
17. Father's Name (First, Middle, Last) Vincent Westberg					18. Mother's Name (First, Middle, Maiden Surname) Catherine Knight										
19a. Informant's Name/Relationship (Type, Print) Catherine Westberg/ Mother					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3933 Colchester Rd. Baltimore, Md 21229										
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore Washington Cre.		Date 7/11/00		20c. Location - City or Town, State Laurel, MD								
21. Signature of Funeral Service Licensee MSK Marshall					22. Name and Address of Facility Gary L. Kaufman Fun'l Home @ Meadowridge Mem. Park Inc. 7250 Washington Blvd. Elkrige, Md 21075										
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <u>HANGING</u> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE												
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year) FOUND 7/9/00		28b. Time of injury 2:21 M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred SUBJECT HANGED SELF						
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) AT HOME			28f. Location (Street and Number or Rural Route Number, City or Town, State) 3933 COLCHESTER RD BALTIMORE, MD												
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										29b. Signature and title of certifier J. M. D.		29c. License number OCME		29d. Date signed (Month, Day, Year) JULY 10, 2000	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARY G. RIPLEY 111 Penn Street, Baltimore, Maryland 21201															
31. Date filed (Month, Day, Year) JUL 13 2000			32. Registrar's Signature B. A. Sparks												

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

NAME

ADH



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22189

amend item 23a per phy G786 8/31/00 yf

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ella Elizabeth Ates

2. Date of Death

June 14, 2000

3. Time of Death

3:00am

4a. Facility Name (If not institution, give street and number)

6140 Baldrige Circl

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

434-38-9249

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-27-1927

9. Birthplace (State or Foreign Country)

Hodge, LA

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6140 Baldrige Circle

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Home

17. Father's Name (First, Middle, Last)

William Tewell

18. Mother's Name (First, Middle, Maiden Surname)

Frankie Lee Baker

19a. Informant's Name/Relationship (Type, Print)

Vicki Boutlier

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6140 Baldrige Circle, Frederick, MD 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

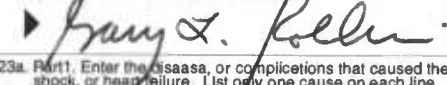
Hodge Cemetery

Date

6-17-2000 Hodge, LA 71247

20c. Location - City or Town, State

21. Signature of Funeral Service Licenses



22. Name and Address of Facility

Gary L. Rollins Funeral Home 21701  
110 West South Street, Fred., MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or head failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

congestive

Congestive Cardiomyopathy.

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 years

b. chronic airway obstruction.

Due to (or as a consequence of):

c. congestive heart failure.

Due to (or as a consequence of):

2 years

d. Diabetes.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier



29c. License number

D42641

29d. Date signed (Month, Day, Year)

6-14-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen Lee MD 610 Solaris Ct. Frederick, MD 21703

31. Date filed (Month, Day, Year)

JUN 15 2000

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
800-555-5555

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22190

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Beulah Odelia

Anderson

2. Date of Death

June 29, 2000 Year

3. Time of Death

5:50 AM

4a. Facility Name (If not institution, give street and number)

7024 Edgemont Road

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

220-16-9457

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 20, 1904

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7024 Edgemont Road

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Waitress

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

Benjamin

Hulver

18. Mother's Name (First, Middle, Maiden Surname)

Almedia Lovella Unknown

19a. Informant's Name/Relationship (Type, Print)

Mrs. Lillie Mae Hill, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7024 Edgemont Road, Frederick, Maryland 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mount Olivet Cemetery, July 1, 2000

Date

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee

Richard E. Gray M00255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home  
106 East Church St., Frederick, Md. 2170123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *atherosclerotic cardiovascular disease 20 years*  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Stroke, chronic obstructive  
pulmonary disease, osteoarthritis,  
osteoporosis*

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Al. S. Hootch MD

29c. License number

D 35183

29d. Date signed (Month, Day, Year)

June 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Al. S. Hootch MD 300 W 9th St Frederick MD

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-358-2000.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22191

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LUCILLE E. BARNES

2. Date of Death

JUNE 27, 2000

3. Time of Death

10:22 AM

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

133-10-9284

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUG. 6, 1914

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD.

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

9701- VEIRS DRIVE

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

AT HOME

17. Father's Name (First, Middle, Last)

ERNEST R. WITTE

18. Mother's Name (First, Middle, Maiden Surname)

EMMA KURTZHOLTZ

19a. Informant's Name/Relationship (Type, Print)

MARY LU BELOTE-DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

213- BIRCH STREET, NE, LEESBURG, VA. 20176

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

UNION CEMETERY

Date

6/29/2000-LEESBURG, VA.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HYSONG CO., INC.

6510- 16th ST., NW, WASH., DC

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Approximate Interval Between Onset and Death

ONE HOUR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 39934

29d. Date signed (Month, Day, Year)

JUNE 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STEVEN COULTER, MD - 15201- SHADY GROVE RD. #202, ROCKVILLE, MD. 20850

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Gerald Brooks, Jr.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GERALD PHILLIP BROOKS JR

2. Date of Death

June 26, 2000

3. Time of Death

1157 am

4a. Facility Name (If not institution, give street and number)

100 Kerby Parkway

4b. City, Town, or Location of Death

Oxon Hill

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-90-2612

6. Sex

M 2 ☐ F

7. Age (In yrs. last birthday)

35

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

AUGUST 6, 1964

9. Birthplace (State or Foreign Country)

WASHINGTON DC

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

FORESTVILLE, MD

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2723 LORRING DR. #201

10f. Zip Code

20746

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

DISABLED

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

GERALD PHILLIP BROOKS SR

18. Mother's Name (First, Middle, Maiden Surname)

CHARLENE WALKER

19a. Informant's Name/Relationship (Type, Print)

CHARLENE BROOKS/ MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2723 LORRING DR. #201, FORESTVILLE, MD 20746

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

HARMONY MEMORIAL PARK

Date

7-1-00

20c. Location - City or Town, State

LANDOVER, MD

21. Signature of Funeral Service Licensee

Katherine Anne M1085

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOME  
5538 MARLBORO PIKE, FORESTVILLE, MD 2074723a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

a. Occlusive Pulmonary Thrombosis

b. Deep Vein Thrombosis in

c. Association with Hypertensive

d. and Atherosclerotic Cardiovascular Disease

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) at scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joseph Pestaner MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

[Signature]

State  
Registrar

3 0/3

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

③

*Handwritten signature or scribble*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22193

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

MIGUEL ANTONIO BAERGA

2. Date of Death

Month  
JUNEDay  
24Year  
2000

3. Time of Death

9:54 PM

4a. Facility Name (If not institution, give street and number)

National Institute of Health

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

126 48 0710

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

39

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

December 18, 1960 New Jersey

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

400 Mannakee Street

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 6/29/84  
10/27/8413. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☒ Yes 2 ☐ No Specify: Puerto Rican14. Race - American Indian,  
Black, White, etc.

Specify: Hispanic

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Horticulturist

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Pedro Baerga

18. Mother's Name (First, Middle, Maiden Surname)

Catalina Gonzalez

19a. Informant's Name/Relationship (Type, Print)

Margarita Torres/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1892 Andrews Avenue #4E Bronx, NY 10453

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

6-29

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

J. J. Baerga

22. Name and Address of Facility

MARSHALL'S FUNERAL HOME OF MD

4308 Suitland Road Suitland, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. SEPTIC SHOCK

Due to (or as a consequence of):

b. AIDS

Due to (or as a consequence of):

c. Kaposi Sarcoma

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Days

years

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Maria Jison MD

29c. License number

D0054450(MD)

29d. Date signed (Month, Day, Year)

6/25/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIA JISON

9000 ROCKVILLE PIKE, BETHESDA, MD 20892

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

A. Jison

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22194

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Agnes Marie Bates

2. Date of Death  
Month Day Year  
June 26, 20003. Time of Death  
1:05PM

4a. Facility Name (If not institution, give street and number)

Magnolia Garden

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral  
Director5. Social Security Number  
214-30-04536. Sex  
1 ☐ M 2 ☒ F7. Age (In yrs. last birthday)  
92 Yrs.If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)  
March 29, 19089. Birthplace (State or Foreign  
Country)  
Maryland

Usual Residence of Decedent

10a. State  
MD10b. County  
Prince George's10c. City, Town or Location  
Cheverly10d. Inside City Limits  
1 ☒ Yes 2 ☐ No

10e. Street and Number

1705 62nd Avenue

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: Black15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Garfield Smith

18. Mother's Name (First, Middle, Maiden Surname)

Martha Bowie

19a. Informant's Name/Relationship (Type, Print)

Irma Parker-Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1258 Booker Terr

Seat Pleasant MD 20743

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Memorial Park

Date

6-30-00

20c. Location - City or Town, State

Landover MD

21. Signature of Funeral Service Licensee

J.B. Jenkins

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Rd Landover MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Dementia  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Y/S

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

N. J. Jenkins M.D.

29c. License number

D41978

29d. Date signed (Month, Day, Year)

6-27-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nader Tavakoli M.D.

PGH cheverly M.D 20785

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

B. Smith

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-343-0000.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22195

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Moises V. Bautista</b>				2. Date of Death Month Day Year <b>June 22, 2000</b>		3. Time of Death <b>9:50 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Villa Rosa Nursing Home</b>				4b. City, Town, or Location of Death <b>Mitchellville</b>		4c. County of Death <b>Prince Georges</b>	
Funeral Director	5. Social Security Number <b>578-10-9993</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>88</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>July 1, 1911</b>		9. Birthplace (State or Foreign Country) <b>Philippines</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Suitland</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>2500 Porter Avenue</b>				10f. Zip Code <b>20746</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Security Guard</b>		16b. Kind of Business/Industry <b>National Gallery of Art</b>		
17. Father's Name (First, Middle, Last) <b>Pedro Bautista</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marta Velasco</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Alfonso V. Bautista/Nephew</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3501 Fortuna Court, Huntingtown, Md. 20639</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veterans Cheltenham 6/27/2000 Cheltenham, MD</b>		Date		20c. Location - City or Town, State		
21. Signature of Funeral Service Licensed <b>George P. Kalas</b>				22. Name and Address of Facility <b>George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, MD 20745</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Recurrent Aspiration Pneumonia months</b> Due to (or as a consequence of): <b>b. Severe Chronic Obstructive Pulmonary Disease Months</b> Due to (or as a consequence of): <b>c. old Cerebral infarct months</b> Due to (or as a consequence of): <b>d.</b>								
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b>								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Rakesh Arora, MD</b>				29c. License number <b>D 20108</b>		29d. Date signed (Month, Day, Year) <b>6/23/00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Rakesh Arora, M.D. 14300 Gallant Fox Lane, Suite 222, Bowie, MD 20715</b>								
31. Data filed (Month, Day, Year) <b>JUN 27 2000</b>				32. Registrar's Signature <b>[Signature]</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JOHN & SONS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22196

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Maria Pilar Redondo Bucero</b>				2. Date of Death Month Day Year <b>June 23 2000</b>		3. Time of Death <b>1:40 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>12215 Foxhill Lane</b>				4b. City, Town, or Location of Death <b>Bowie</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>217-35-9510</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 15, 1912</b>		9. Birthplace (State or Foreign Country) <b>Spain</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Bowie</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>12215 Foxhill Lane</b>			10f. Zip Code <b>20715</b>		10g. Citizen of What Country? <b>United States</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>Spanish</b>		14. Race - American Indian, Black, White, etc. Specify: <b>Spanish</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>-0-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Francisco Redondo</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Juliana Bucero</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Aurora M. Harris - Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12215 Foxhill Lane Bowie, Maryland 20715</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Huntt Crematory</b>		Date <b>June 25, 2000</b>		20c. Location - City or Town, State <b>Waldorf, Maryland</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie, Maryland 20715</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Alzheimer's Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>5 years</b>							Approximate Interval Between Onset and Death <b>5 years</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
Medical Certification: To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred					
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		28e. Date of Injury (Month, Day, Year)					
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
State Registrar	29b. Signature and title of certifier  M.D.				29c. License number <b>D 24721</b>		29d. Date signed (Month, Day, Year) <b>6/23/2000</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SYBIL STARR 14333 LAUREL HILL ROAD LAUREL MD 20708</b>							
31. Date filed (Month, Day, Year) <b>JUN 27 2000</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 22197

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marian Louise Bailey

2. Date of Death  
Month Day Year  
June 9 2000

3. Time of Death  
0230

4a. Facility Name (If not institution, give street and number)

Calvert Manor Health Care Center

4b. City, Town, or Location of Death

Rising Sun

4c. County of Death

Cecil

5. Social Security Number

221-24-7889

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

11/28/1906

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Cecil

10c. City, Town or Location

Cecilton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

120 Center Street

10f. Zip Code

21913

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Charles Long

18. Mother's Name (First, Middle, Maiden Surname)

Emma Taylor

19a. Informant's Name/Relationship (Type, Print)

Margaret O'Neal/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 308 Cecilton, Md. 21913

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Pauls

Date

6/13/00

20c. Location - City or Town, State

Earlville, Md

21. Signature of Funeral Service Licensee

*John Fellows*

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home  
370 W. Cypress St. Millington, Md. 21651

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Dementia*

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*2-3 yrs*

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Type II DM*

Due to (or as a consequence of):

*> 5 yrs*

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation

2 ☐ Accident 6 ☐ Could not be determined

3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Joseph Weidner*

29c. License number

044373

29d. Date signed (Month, Day, Year)

6/17/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Joseph Weidner Chesapeake Family Practice

101 Colonial Way

Rising Sun, Md. 21911

31. Date filed (Month, Day, Year)

JUN 12 2000

32. Registrar's Signature

*B. Sparks*

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

*[Handwritten signature]*

JUN 18 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22198

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jessie H. Buckner</b>				2. Date of Death Month <b>07</b> Day <b>03</b> Year <b>00</b>				3. Time of Death <b>10:45 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Prince George Hospital</b>				4b. City, Town, or Location of Death <b>Cheverly</b>				4c. County of Death <b>Prince George</b>	
Funeral Director	5. Social Security Number <b>228-44-5902</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>03-11-34</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>	
	Usual Residence of Decedent									
10a. State <b>MD</b>		10b. County <b>Prince George</b>		10c. City, Town or Location <b>Capitol Heights</b>				10d. Inside City Limits <b>1</b> Yes <b>2</b> No		
10e. Street and Number <b>4712 Gunther Street</b>				10f. Zip Code <b>20743</b>				10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>09</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Foreman</b>				16b. Kind of Business/Industry <b>Landscaping</b>		
17. Father's Name (First, Middle, Last) <b>David Buckner, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Alice Hughston</b>						
19a. Informant's Name/Relationship (Type, Print) <b>David Buckner, Jr. - Brother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>137 53rd St., SE - Apt. #3-Washington, DC 20019</b>						
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Buckner Family Cemetery</b>		Date <b>07-10-00</b>		20c. Location - City or Town, State <b>Louisa, VA</b>				
21. Signature of Funeral Service Licensee <b>John E. Thomasson</b>				22. Name and Address of Facility <b>Thomasson's Funeral Service, Inc. P.O. Box 512 - Louisa, VA 23093</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Carcinoma Lung with Metastases</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>1 year</b>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown										
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No										
24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No										
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)								
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and title of certifier <b>Paul A. DeVere</b>				29c. License number <b>D01852</b>		29d. Date signed (Month, Day, Year) <b>JULY 5 2000</b>				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>PAUL A. DeVERE MD 4203 QUEENSBURY Rd Hyattsville MD 20781</b>										
31. Date filed (Month, Day, Year) <b>JUL 13 2000</b>		32. Registrar's Signature <b>Benjamin A. Sparks</b>								

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22199

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS VIRGINIA BROOKS

2. Date of Death

Month Day Year  
June 23 2000

3. Time of Death

0510

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

214-32-0139

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN. 22, 1935

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

ROUTE 1 BOX 615

10f. Zip Code

21601

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

08

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

DOMESTIC ENGINEER

16b. Kind of Business/Industry

PRIVATE FAMILY

17. Father's Name (First, Middle, Last)

CHARLES E. WALTER WOODS

18. Mother's Name (First, Middle, Maiden Surname)

DOROTHY V. BROOKS

19a. Informant's Name/Relationship (Type, Print)

DWAYNE BROOKS/ SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8163 JUNEWAY EASTON, MD. 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ST. STEPHENS CHURCH 6/29/00

Date

20c. Location - City or Town, State

EASTON, MD

21. Signature of Funeral Service Licensee

DASHIELL FUNERAL SERVICES  
319 E. DOVER ST. EASTON, MD. 21601

22. Name and Address of Facility

DASHIELL FUNERAL SERVICES  
319 E. DOVER ST. EASTON, MD. 2160123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

PULMONARY EMBOLUS

Approximate  
Interval Between  
Onset and Death

IMMEDIATE

Due to (or as a consequence of):

RIGHT HEMIPARESIS

YEARS

Due to (or as a consequence of):

LEFT CVA

YEARS

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

David B. Danner MD

29c. License number

D50502

29d. Date signed (Month, Day, Year)

6/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID B. DANNER MD 219 S. WASHINGTON ST. EASTON, MD. 21601

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

Benita B. Sparks

State  
RegistrarPhysician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22200

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>William A. Buxton</b>				2. Date of Death Month Day Year <b>June 25, 2000</b>		3. Time of Death <b>7:30pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>19131 Stedwick Drive</b>				4b. City, Town, or Location of Death <b>Montgomery Village</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>340-32-7544</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>60</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 10, 1939</b>	
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>Illinois</b>		10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>Montgomery Village</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>19131 Stedwick Drive</b>	
	10f. Zip Code <b>20886</b>				10g. Citizen of What Country? <b>United States</b>		11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
To Be Completed by Physician/Medical Examiner	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Consultant</b>		16b. Kind of Business/Industry <b>Technical writing</b>		17. Father's Name (First, Middle, Last) <b>Robert A. Buxton</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Margarethe A. Olson</b>	
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Jo Alice Buxton/ Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19131 Stedwick Drive, Montgomery Village Md 20886</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Memorial Park</b>		20c. Location - City or Town, State <b>Rockville, Maryland</b>		20d. Date <b>6/30/2000</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Jodel D. Wynn</i>				22. Name and Address of Facility <b>Olin L. Molesworth P. A. Funeral Home</b> <b>26401 Ridge Road, Damascus, Maryland 20872</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>METASTATIC PROSTATE CANCER</b> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death <b>4 YRS.</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ANEMIA</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Marlene J. Hayman</i>		29c. License number <b>MD 31362</b>		29d. Date signed (Month, Day, Year) <b>June 26, 2000</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Marlene Hayman M.D. 501 N. Frederick Ave. Gaithersburg, Maryland 20877</b>							
State Registrar	31. Date filed (Month, Day, Year) <b>JUN 28 2000</b>		32. Registrar's Signature <i>[Signature]</i>					

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22201

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

George H. Butler, Jr.

2. Date of Death

June 25, 2000

3. Time of Death

1:30 PM

4a. Facility Name (If not institution, give street and number)

22200 Davis Mill Road

4b. City, Town, or Location of Death

Germantown

4c. County of Death

Montgomery

5. Social Security Number

218-24-1040

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 16, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Germantown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

22200 Davis Mill Road

10f. Zip Code

20876

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1951-53

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Fruit Grower

16b. Kind of Business/Industry

Orchard

17. Father's Name (First, Middle, Last)

George Henry Butler, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Carrie Blue

19a. Informant's Name/Relationship (Type, Print)

Todd H. Butler - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21900 Wildcat Road, Germantown, Maryland 20876

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salem Cemetery

Date

6/29/2000 Germantown, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert L. Williams

22. Name and Address of Facility

Olin L. Molesworth P.A., Funeral Home

26401 Ridge Road, Damascus, Maryland

20872-0117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or renal failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Parkinson's Disease  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

adenocarcinoma of prostate  
Reflux Esophagitis  
Hypertension; Multiple TIA's

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ NoHospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Tibor E. Frekko

29c. License number

DO 3716

29d. Date signed (Month, Day, Year)

June 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tibor E. Frekko, M.D. 19211 Montgomery Village Ave., Montgomery Village, Maryland 20886

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-534-2025.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22202

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Glenn Franklin Bowers, Jr.

2. Date of Death  
Month Day Year

June 23, 2000

3. Time of Death

10:44 PM

4a. Facility Name (If not institution, give street and number)

College View Nursing Center

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

215-26-7750

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Aug. 10, 1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Jefferson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3232 Jefferson Pike

10f. Zip Code

21755

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

self

16b. Kind of Business/Industry

welder

17. Father's Name (First, Middle, Last)

Glenn Franklin Bowers, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Redmond

19a. Informant's Name/Relationship (Type, Print)

Helen Bowers, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3232 Jefferson Pike, Jefferson, MD 21755

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Resthaven Memorial Gardens

Date

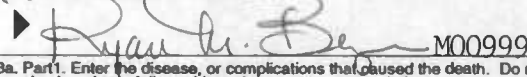
6/27

2000

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

 Keeney and Basford Funeral Home  
 106 East Church Street, Frederick, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic colon cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

 1 ☐ Natural 5 ☐ Pending investigation  
 2 ☐ Accident 6 ☐ Could not be determined  
 3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

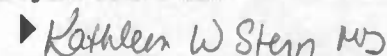
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D32073

29d. Date signed (Month, Day, Year)

6/27/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kathleen W Stern MD 610 Ninth Ave Brunswick Md 21716

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22203

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT BURDETTE BALDWIN

2. Date of Death

Month Day Year  
July 2 2000

3. Time of Death

5:18 PM

4a. Facility Name (If not institution, give street and number)

Fort Washington Hospital

4b. City, Town, or Location of Death

Fort Washington Prince Georges

4c. County of Death

Funeral  
Director

5. Social Security Number

218-05-5040

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
August 19, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Charles

10c. City, Town or Location

Bryans Road

10d. Inside City Limits

1 ☐ Yes ☒ No

10e. Street and Number

6711 Amherest Road

10f. Zip Code

20616

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Auto

17. Father's Name (First, Middle, Last)

Randolph Baldwin, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Sadie Elliott Baldwin

19a. Informant's Name/Relationship (Type, Print)

Edna L. McCoy/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2160 Fairport Road Reedville, VA 22539

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Antomment Trinity Memorial Gar. 7/6/00 Waldorf, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

M00945  
AREHART-ECHOLS FUNERAL HOME, P.A.  
P.O. BOX 567 LA PLATA, MD. 20646

22. Name and Address of Facility

AREHART-ECHOLS FUNERAL HOME, P.A.  
P.O. BOX 567 LA PLATA, MD. 20646

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Congestive heart Failure

Due to (or as a consequence of):

Coronary artery disease

b.

Due to (or as a consequence of):

Aortic Stenosis

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

7 years

7 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute renal failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sloay Sr

29c. License number

D0042707

29d. Date signed (Month, Day, Year)

7/3/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

George Bren, M.D. 3600 Leonardtown Rd. Suite 103 Waldorf, MD 20601

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 05 2000

32. Registrar's Signature

Brenna B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22204

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ANITA LOUISE BOBLETT</b>				2. Date of Death Month Day Year <b>JULY 3 2000</b>				3. Time of Death <b>10:25 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>MARYLAND GENERAL HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>				4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>235-52-0842</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>FEBRUARY 26, 1937</b>		9. Birthplace (State or Foreign Country) <b>WEST VIRGINIA</b>		
	Usual Residence of Decedent				10c. City, Town or Location <b>WALDORF</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
10e. State <b>MARYLAND</b>		10b. County <b>CHARLES</b>		10f. Zip Code <b>20601</b>				10g. Citizen of What Country? <b>U.S.A.</b>			
10e. Street and Number <b>2502 LISA DRIVE</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:	
14. Raza - American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collegiate (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>	
17. Father's Name (First, Middle, Last) <b>JACK ARNOLD WOOTEN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>VERNA VICTORIA STONE</b>				19a. Informant's Name/Relationship (Type, Print) <b>CINDY L. HARDY/DAUGHTER</b>			
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13025 HICKORY AVE., WALDORF, MARYLAND 20601</b>				20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>THE HUNTT CREMATORY</b>		20c. Location - City or Town, State <b>WALDORF, MARYLAND</b>	
21. Signature of Funeral Service Licensee <b>JOHN P. KNISLEY</b>				22. Name and Address of Facility <b>THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604-0156</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Aspiration Pneumonia</b>			
23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23c. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Mitchel Dave M.D.</b>				29c. License number <b>89290</b>		29d. Date signed (Month, Day, Year) <b>7/3/00</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mitchel Dave, M.D. c/o Maryland General Hospital</b>				31. Date filed (Month, Day, Year) <b>JUL 05 2000</b>				32. Registrar's Signature <b>B. Sparks</b>			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22205

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Louise Baxter

2. Date of Death

Month  
July

Day

2

Year

2000

3. Time of Death

1:20 AM

4a. Facility Name (If not institution, give street and number)

2237 Sandalwood Drive

4b. City, Town, or Location of Death

Waldorf

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

577-44-2916

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Dec. 27, 1932

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Cobb Island

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18226 Piedmont Drive

10f. Zip Code

20672

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Bus Driver

16b. Kind of Business/Industry

Prince George's County  
Board of Education

17. Father's Name (First, Middle, Last)

Charles Eugene Evans

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Davis

19a. Informant's Name/Relationship (Type, Print)

Leon F. Baxter/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18226 Piedmont Drive, Cobb Island, Maryland 20672

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

St. Barnabas Cemetery 07-05-2000 Upper Marlboro, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

JOHN P. KNISLEY MO1164

22. Name and Address of Facility

The Hunt Funeral Home, Inc.  
P. O. Box 156, Waldorf, Maryland 2060423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Renal Cell Cancer with metatasis to brain

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

at son's home

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Medical Examiner2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
3 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Krishan Mathur

29c. License number

D28352

29d. Date signed (Month, Day, Year)

July 3, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 05 2000

32. Registrar's Signature

Krishan Mathur

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
202-342-1000.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22206

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PHILLIP HERMAN BOND</b>				2. Date of Death Month Day Year <b>July 2 2000</b>		3. Time of Death <b>7:51 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Civista Medical Center</b>				4b. City, Town, or Location of Death <b>LaPlata</b>		4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>578-52-5211</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>60</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 17 1940</b>		9. Birthplace (State or Foreign Country) <b>Washington, DC</b>
	Usual Residence of Decedent				10c. City, Town or Location <b>Waldorf</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10a. State <b>Maryland</b>		10b. County <b>Charles</b>		10e. Street and Number <b>6730 Mink Court</b>		10f. Zip Code <b>20603</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give A Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Fireman</b>		16b. Kind of Business/Industry <b>Government</b>		
17. Father's Name (First, Middle, Last) <b>Unknown</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ruby Gray Owens</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Irving W. Gray Jr (PRD)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6730 Mink Court Waldorf, MD 20603</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>7-4-00 Alexandria, VA</b>		
21. Signature of Funeral Service Licensee  <b>MO0173</b>				22. Name and Address of Facility <b>Eberwein Funeral Services 4433 White Pls 1a White Pls., MD 20695</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive Heart Failure</b> Due to (or as a consequence of): <b>b. Pneumonia</b> Due to (or as a consequence of): <b>c. Sepsis</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>years</b> <b>days</b> <b>days</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Periphereal Vascular Disease</b> <b>Agotemia</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier 				29c. License number <b>D-46046</b>		29d. Date signed (Month, Day, Year) <b>7-2-00</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Amir A Mirza Alikhani, MD, FCCP 118 LaGrange Ave P.O.Box 1890 LaPlata MD 20646</b>								
31. Date filed (Month, Day, Year) <b>JUL 05 2000</b>				32. Registrar's Signature 				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22207

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH

BARSTLER

BUCHER

2. Date of Death

Month

Day

Year

June 23, 2000

3. Time of Death

2:00AM

4a. Facility Name (If not institution, give street and number)

SALISBURY CENTER: GENESIS ELDERCARE

4b. City, Town, or Location of Death

SALISBURY, MD

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

199-14-6454

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
December 24, 1924

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2021 Wildwood Trail

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Roscoe

Barstler

18. Mother's Name (First, Middle, Maiden Surname)

Grace

Campbell

19a. Informant's Name/Relationship (Type, Print)

Ellen McAllen/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2021 Wildwood Trail, Pocomoke City, MD 21851

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Rosemont Cemetery

Date

6/26/00

20c. Location - City or Town, State

Bloomsburg, PA

21. Signature of Funeral Service Licensee

MO1051

22. Name and Address of Facility

Holloway-Melson Funeral Home Professional Assoc.

103 Linden Ave., Pocomoke City, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. *Unseptic*  
Due to (or as a consequence of):*days*Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. *coronary artery disease*  
Due to (or as a consequence of):*year*c. *Diabetes*  
Due to (or as a consequence of):*year*d. *peripheral vascular disease*  
Due to (or as a consequence of):*year*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D-29349

29d. Date signed (Month, Day, Year)

6/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILLIAM ROBINS, M.D., 1104 HEALTHWAY DR., SALISBURY, MD 21804

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

*James B. Sparks*State  
RegistrarSARAH BARSELE BUCHER  
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22208

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) EUGENE L. CARROLL				2. Date of Death Month Day Year June 27, 2000		3. Time of Death 2:20 P.M.		
	4a. Facility Name (If not institution, give street and number) MARINER HEALTH OF SOUTHERN MARYLAND				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 578-05-7663		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 97 Yrs.		8. Date of Birth (Month, Day, Year) July 21, 1902		
	9. Birthplace (State or Foreign Country) Wash., D.C.		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Clinton		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 9211 Stuart Lane		10f. Zip Code 20735		10g. Citizen of What Country? United States	
11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: African American			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Musician/Contractor		16b. Kind of Business/Industry Self-Employed					
17. Father's Name (First, Middle, Last) Robert Carroll		18. Mother's Name (First, Middle, Maiden Surname) Christine Young							
19a. Informant's Name/Relationship (Type, Print) Martin E. Carroll, Sr. - Son		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2008 Jameson St., Temple Hills, MD 20748							
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Olivet Cemetery		20c. Location - City or Town, State Washington, D.C.					
21. Signature of Funeral Service Licensee John T. Stewart, III		22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. Massive upper Gastro-Intestinal bleeding & hypotension Due to (or as a consequence of): b. dementia Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death 1hr					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier Attending		29c. License number D-24535		29d. Date signed (Month, Day, Year) 6.29.00			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi N. Berwa, 7700 Old Branch Ave., Suite C-101, Clinton, MD 20735									
31. Date filed (Month, Day, Year) JUN 30 2000		32. Registrar's Signature B. B. B.							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



0005 0 7 HUG

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22209

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harold Chase

2. Date of Death  
Month Day Year  
June 25, 20003. Time of Death  
2:20 AM

4a. Facility Name (If not institution, give street and number)

Mariner Health of Greater Laurel

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

226362611

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar 21, 1926

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Prince Georges

10c. City, Town or Location

Beltsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

5401 Odell Road

10f. Zip Code

20705

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Store Manager

16b. Kind of Business/Industry

US Gov't

17. Father's Name (First, Middle, Last)

Lorenzo Chase

18. Mother's Name (First, Middle, Maiden Surname)

Eva Chivies

19a. Informant's Name/Relationship (Type, Print)

Loretta Chase (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5401 Odell RD, Beltsville MD 20705

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Bethel Cemetery

Date

7/1/2000 Alexandria Va.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Greene Funeral Home Inc  
814 Franklin ST, Alexandria, VA 22314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

ACUTE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred


28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

D24997

29d. Date signed (Month, Day, Year)

6/27/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LUIS A. CASAS MD 8317 CHERRY LAKE LAUREL MD. 20707

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 22210

Amend #18, Per Family PGC 7-3-00 cr

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ELSIE L. Cunningham

2. Date of Death

Month Day Year  
June 24 2000

3. Time of Death

2222

4a. Facility Name (If not institution, give street and number)

1008 Marcy Avenue #103

4b. City, Town, or Location of Death

Oxon Hill

4c. County of Death

Prince George's

5. Social Security Number

578-50-6947

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 26, 1936

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

D.C.

10b. County

N/A

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1008 Marcy Ave. # 103

10f. Zip Code

20020

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private Duty

17. Father's Name (First, Middle, Last)

Charles Matthews

18. Mother's Name (First, Middle, Maiden Surname)

~~UNKNOWN~~ Luvern Little

19a. Informant's Name/Relationship (Type, Print)

Wanda A. Cunningham/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1008 Marcy Ave. #103, Oxon Hill MD 20745

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Forest Hills Cemetery

Date

7-1-00

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

Julia P. Marshall

22. Name and Address of Facility

Marshall's Funeral Home, Inc.

4217 9th Street N.W. Washington DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Salvador Alvarez, DO

29c. License number

H0055927

29d. Date signed (Month, Day, Year)

June 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador Sylvester, 300 Hospital Drive, Cheverly, Maryland 20785

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 800-555-5555.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

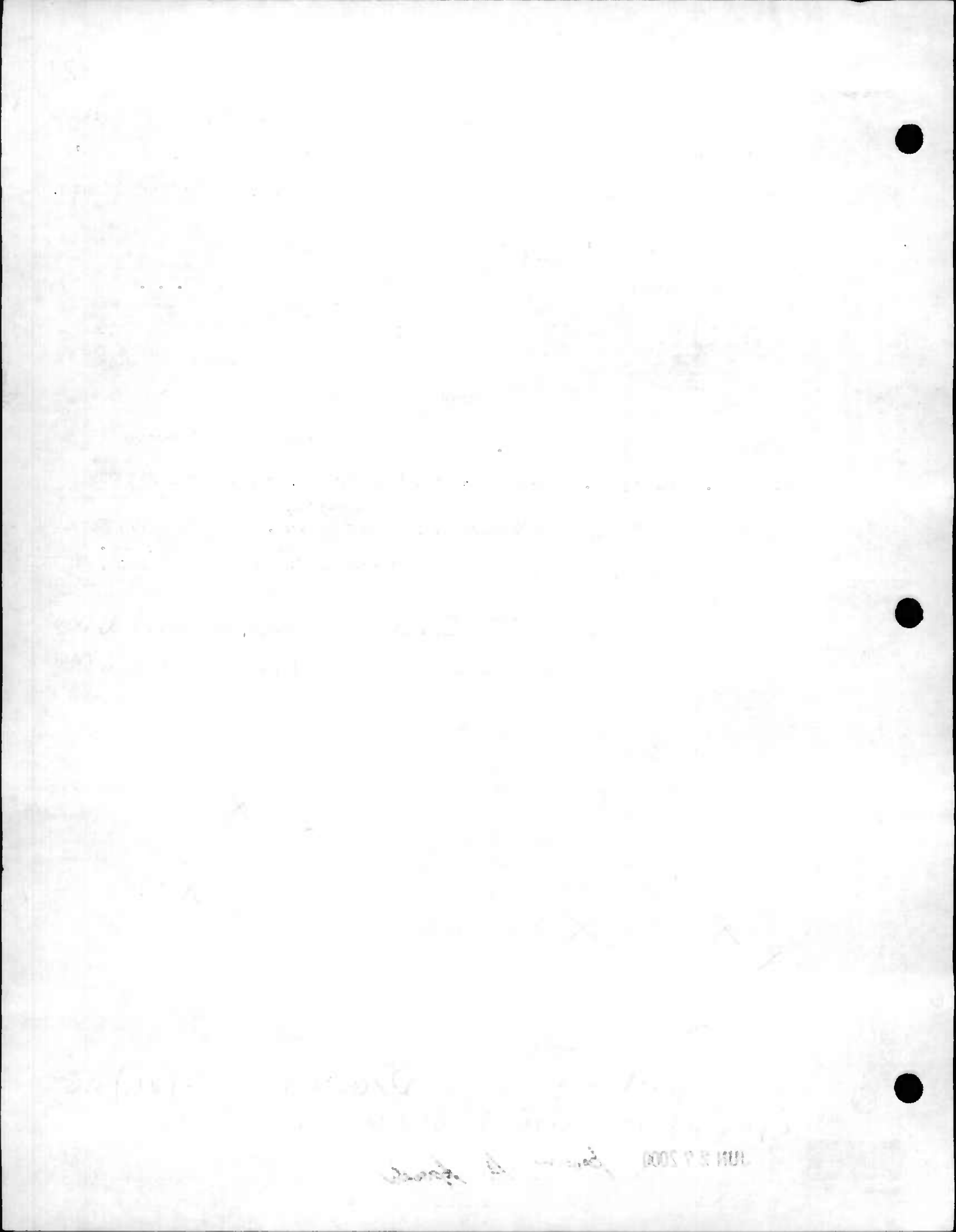
## Certificate of Death

Reg. No.

00 22211

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Diana Lee Coffren				2. Date of Death Month Day Year June 25, 2000				3. Time of Death 9:18PM	
	4a. Facility Name (If not institution, give street and number) Southern Maryland Hospital				4b. City, Town, or Location of Death Clinton				4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 258-15-8125		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) Yrs. 51		8. Date of Birth (Month, Day, Year) April 21, 1949		9. Birthplace (State or Foreign Country) Washington DC	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Clinton				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number 8221 Golden Drive				10f. Zip Code 20735		10g. Citizen of What Country? U.S.A.			
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th		College (1-4 or 5+) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Home		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) Demon William Talbert, Sr.				18. Mother's Name (First, Middle, Maiden Surname) Margaret Estell Reeves					
	19a. Informant's Name/Relationship (Type, Print) Robert E. Coffren, Sr. (Husband)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8221 Golden Drive Clinton, Maryland 20735					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Maryland State Veterans Cem.		Date June 29, 2000		20c. Location - City or Town, State Cheltenham, Maryland			
	21. Signature of Funeral Service Licensee <i>Keeli R. Patter</i>				22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
	Immediate Cause (Final disease or condition resulting in death) a. <i>Non-Small Cell Carcinoma of Lung</i>									
	Due to (or as a consequence of): b. <i>Metastasis to Lymph Nodes</i>									
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. d. Due to (or as a consequence of):									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown									
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					24b. Were autopsy findings available prior to completion of cause of death? N/A <input type="checkbox"/> Yes <input type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
State Registrar	29b. Signature and title of certifier <i>George J. Waldorf</i>				29c. License number D20629		29d. Date signed (Month, Day, Year) 6/26/00			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) George J. Waldorf WALDORE.mil 20603									
State Registrar	31. Date filed (Month, Day, Year) JUN 27 2000				32. Registrar's Signature <i>George J. Waldorf</i>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22212

amend item 24a per phys. G787 9/5/00 yf  
Amended line1, fchd idPhysician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Lois Virginia Crompton  
~~Lois Virginia Crompton~~

2. Date of Death

Month Day Year  
May 30 2000

3. Time of Death

2:47pm

4a. Facility Name (If not institution, give street and number)

410 Birmingham Drive

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

327-03-7225

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 13, 1916

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

410 Birmingham Drive

10f. Zip Code

21701

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harold A. Dunsworth

18. Mother's Name (First, Middle, Maiden Surname)

Beulah V. Unknown

19a. Informant's Name/Relationship (Type, Print)

Steven Crompton (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

410 Birmingham Drive, Frederick, Maryland 21701

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory

Date

6/1/00

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.  
1201 NORTH MARKET ST., FREDERICK, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASCVD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician:2 ☒ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35164

29d. Date signed (Month, Day, Year)

5/31/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1080 W. Patrick St. Frederick, MD 21703

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 06 2000

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22213

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VALARIE C. COOPER

2. Date of Death  
Month Day Year  
JUNE 27, 20003. Time of Death  
12:30amFuneral  
Director

4a. Facility Name (If not institution, give street and number)

TALBOT HOSPICE HOUSE

4b. City, Town, or Location of Death

EASTON

4c. County of Death

TALBOT

5. Social Security Number

212-86-0553

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

36

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

JUL. 29, 1963

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

120 S. HIGGINS ST.

10f. Zip Code

21601

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

NURSING ASSISTANT

16b. Kind of Business/Industry

NURSING HOME

17. Father's Name (First, Middle, Last)

MELVIN CONWAY

18. Mother's Name (First, Middle, Maiden Surname)

EMMA C. COLLINS

19a. Informant's Name/Relationship (Type, Print)

CHRISTINE BURKE/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

404 SOUTH ST. EASTON, MD. 21601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

RICHARDSON CEMETERY 7/3/00

20c. Location - City or Town, State

EASTON, MD.

21. Signature of Funeral Service Licensee

Dashed

22. Name and Address of Facility

DASHIELL FUNERAL SERVICES

319 E. DOVER ST. EASTON, MD. 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Breast Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 yrs

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Dashed

29c. License number

D39887

29d. Date signed (Month, Day, Year)

6/27/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID SMITH MD 29466 PINTAIL DRIVE, EASTON, MD. 21601

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

Dashed

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jackie Loy Corbett, III</b>				2. Date of Death Month Day Year <b>JUNE 27 2000</b>				3. Time of Death <b>1310</b>	
	4a. Facility Name (If not institution, give street and number) <b>WASHINGTON COUNTY HOSPITAL</b>				4b. City, Town, or Location of Death <b>HAGERSTOWN</b>				4c. County of Death <b>WASHINGTON</b>	
Funeral Director	5. Social Security Number <b>215-96-8912</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>19</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 21, 1980</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>West Virginia</b>			10b. County <b>Berkeley</b>			10c. City, Town or Location <b>Falling Waters</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>246 Appaloosa Drive</b>				10f. Zip Code <b>25419</b>				10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Processor</b>				16b. Kind of Business/Industry <b>Federal Government</b>		
17. Father's Name (First, Middle, Last) <b>Jackie Loy Corbett, II</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Jean Louise McCormick</b>				
19a. Informant's Name/Relationship (Type, Print) <b>J. Louise McCormick/Mother</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>246 Appaloosa Drive Falling Waters, WV 25419</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Smithsburg Crematory June 29, 2000 Smithsburg, Maryland</b>				20c. Location - City or Town, State		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Osborne Funeral Home 425 S. Conococheague St. Williamsport, MD 21795</b>						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>Immediate Cause (Final disease or condition resulting in death)</b> <b>NARCOTIC INTOXICATION</b>  <b>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b>  a. Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.										
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year) <b>6-27-00</b>		28b. Time of Injury <b>UNKNOWN</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>UNKNOWN</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>						28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>1006 APPALOOSA DR FALLING WATERS, WEST VA.</b>				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier 						29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>JUNE 28, 2000</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. L. HARRON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>										
31. Date filed (Month, Day, Year) <b>JUN 30 2000</b>			32. Registrar's Signature 							





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 22215

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Florence Jean Cairns</b>						2. Date of Death Month Day Year <b>June 27 2000</b>		3. Time of Death <b>3:48 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Montgomery General Hospital</b>						4b. City, Town, or Location of Death <b>Olney</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>263-42-3328</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 21, 1929</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Damascus</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>10124 Lewis Drive</b>				10f. Zip Code <b>20872</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>			16b. Kind of Business/Industry <b>Bechtel Power Corporation</b>			
17. Father's Name (First, Middle, Last) <b>Jacob Lutz</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Bertha M. Plummer</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Miriam R. Leech - Daughter</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>23456 4516 Rothwell Drive, Virginia Beach, Virginia</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Deer Park Cemetery</b>		20c. Location - City or Town, State <b>7/1/2000 Reisterstown, Maryland</b>				
21. Signature of Funeral Service Licensee <b>Robert L. Williams</b>						22. Name and Address of Facility <b>Olin L. Molesworth P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0111</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> <p>a. <b>Cardiogenic Shock</b> Due to (or as a consequence of):</p> <p>b. <b>Acute Myocardial Infarction</b> Due to (or as a consequence of):</p> <p>c. <b>Coronary Heart Disease</b> Due to (or as a consequence of):</p> <p>d. <b>Hyperlipidemia</b></p> </div> <div style="width: 15%;"> <p>Approximate Interval Between Onset and Death</p> <p><b>1 Day</b></p> <p><b>6 Days</b></p> <p><b>Unknown</b></p> <p><b>unknown</b></p> </div> </div>										
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>obesity</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature and Title of Certifier <b>[Signature]</b>						29c. License number <b>D51908</b>		29d. Date signed (Month, Day, Year) <b>June 27 2000</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>David B. Magliaro MD 18111 Prince Phillip Drive Olney Maryland</b>										
31. Date filed (Month, Day, Year) <b>JUL 1 8 2000</b>			32. Registrar's Signature <b>[Signature]</b>							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22216

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WALTER ROGER COCHRAN, JR.

2. Date of Death

Month Day Year  
JUNE 23 2000

3. Time of Death

11:00pm

4a. Facility Name (If not institution, give street and number)

16744 WHITES STORE RD.

4b. City, Town, or Location of Death

BOYDS

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

153-30-4642

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

59

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAY 8 1941

9. Birthplace (State or Foreign Country)

WASH., DC

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

BOYDS

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

16744 WHITES STORE RD.

10f. Zip Code

20841

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

PAINTER

16b. Kind of Business/Industry

HOSPITAL

17. Father's Name (First, Middle, Last)

WALTER ROGER COCHRAN

18. Mother's Name (First, Middle, Maiden Surname)

EVELYN TEREASA JOHNSON

19a. Informant's Name/Relationship (Type, Print)

MIKE COCHRAN / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

360 WINTERWALK DR., GAITHERSBURG, MD 20878

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ENDERS/SHIRLEY F.H.

Date

6/26

20c. Location - City or Town, State

BERRYVILLE, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HILTON FUNERAL HOME  
BOX 86, BARNESVILLE, MD 2083823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Angiographic Cerebral Sclerosis*

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 yrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

033677

29d. Date signed (Month, Day, Year)

JUNE 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDWARD J. BROWN MD 15821 ANANIAS DRIVE ROCKVILLE MD 20879

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar Signature

MD 20879

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2028.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 22217

CROPPER, VIRGINIA

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 800.668.6868.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <i>VIRGINIA E CROPPER</i>		2. Date of Death Month <i>JUNE</i> Day <i>23</i> Year <i>2000</i>		3. Time of Death <i>5:12PM</i>	
4a. Facility Name (If not institution, give street and number) <i>Berlin Nursing and Rehabilitation Ctr.</i>		4b. City, Town, or Location of Death <i>Berlin</i>		4c. County of Death <i>Worcester</i>	
5. Social Security Number <i>212 40 7567</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>97</i> Yrs.	
8. Date of Birth (Month, Day, Year) <i>Aug. 25, 1902</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>			
10a. State <i>Md.</i>		10b. County <i>Worcester</i>		10c. City, Town or Location <i>Berlin</i>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <i>9715 Healthway Drive</i>		10f. Zip Code <i>21811</i>	
10g. Citizen of What Country? <i>US</i>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <i>White</i>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>4</i> Collega (1-4or 5+) <i>4</i>	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Teacher</i>		16b. Kind of Business/Industry <i>Public Schools</i>		17. Father's Name (First, Middle, Last) <i>Joseph Henry Esham</i>	
18. Mother's Name (First, Middle, Maiden Sumama) <i>Jennie Powell</i>		19a. Informant's Name/Relationship (Type, Print) <i>Reese Cropper, Jr.</i>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>9620 Ocean View Lane, Ocean City, Md. 21842</i>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Evergreen Cemetery</i>		20c. Location - City or Town, State <i>6-26-2000 Berlin, Maryland</i>	
21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <i>The Burbage Funeral Home 108 William St., Berlin, Md. 21811</i>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <i>a. Congestive Heart Failure</i> Due to (or as a consequence of): <i>b. Coronary artery disease</i> Due to (or as a consequence of): <i>c.</i> Due to (or as a consequence of): <i>d.</i>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <i>M</i>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>[Signature]</i>		29c. License number <i>D-0048221</i>	
29d. Data signed (Month, Day, Year) <i>6/24/00</i>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <i>Julio M. DePena 18 mason Axon ship CTR selbyville DE</i>		31. Data filed (Month, Day, Year) <i>JUN 27 2000</i>	
32. Registrar's Signature <i>[Signature]</i>					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 22218**

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Richard Denis Davis</b>				2. Date of Death Month <b>June</b> Day <b>24</b> Year <b>2000</b>		3. Time of Death <b>10:00 am</b>																										
	4a. Facility Name (If not institution, give street and number) <b>3545 Madison Place</b>				4b. City, Town, or Location of Death <b>Hyattsville</b>		4c. County of Death <b>Prince George's</b>																										
Funeral Director	5. Social Security Number <b>228-40-0708</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 21, 1921</b>																										
	9. Birthplace (State or Foreign Country) <b>Ireland</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Hyattsville</b>																										
Usual Residence of Decedent																																	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																																	
10e. Street and Number <b>3545 Madison Place</b>				10f. Zip Code <b>20782</b>		10g. Citizen of What Country? <b>U.S.A.</b>																											
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																										
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Railroad Agent</b>			16b. Kind of Business/Industry <b>Railroad</b>																										
17. Father's Name (First, Middle, Last) <b>Joseph Davis</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Bridget Whittle</b>																													
19a. Informant's Name/Relationship (Type, Print) <b>Maureen B. Rice - Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15023 Nashua Lane, Bowie, Maryland 20716</b>																													
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>			20c. Location - City or Town, State <b>Alexandria, Virginia</b>																											
21. Signature of Funeral Service Licensee 			22. Name and Address of Facility <b>Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781</b>																														
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																	
Immediate Cause (Final disease or condition resulting in death)																																	
<table border="0"> <tr> <td rowspan="4">                 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             </td> <td>a.</td> <td><b>Acute Myocardial Infarction</b></td> <td><b>1 Minute</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b.</td> <td><b>Coronary Pulmonale</b></td> <td><b>1 Year</b></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c.</td> <td><b>Chronic Obstructive Lung Disease</b></td> <td><b>10 Years</b></td> <td></td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td colspan="3"></td> </tr> </table>									Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Acute Myocardial Infarction</b>	<b>1 Minute</b>	Due to (or as a consequence of):			b.	<b>Coronary Pulmonale</b>	<b>1 Year</b>	Due to (or as a consequence of):			c.	<b>Chronic Obstructive Lung Disease</b>	<b>10 Years</b>		Due to (or as a consequence of):				d.			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<b>Acute Myocardial Infarction</b>	<b>1 Minute</b>																														
	Due to (or as a consequence of):																																
	b.	<b>Coronary Pulmonale</b>	<b>1 Year</b>																														
	Due to (or as a consequence of):																																
c.	<b>Chronic Obstructive Lung Disease</b>	<b>10 Years</b>																															
Due to (or as a consequence of):																																	
d.																																	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																	
<b>Right Pneumonectomy for Cancer in 1985</b>																																	
<b>Multifocal Atrial Tachycardia</b>																																	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown																																	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																																	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No																																	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No																										
28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																														
28f. Location (Street and Number or Rural Route Number, City or Town, State)																																	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																	
29b. Signature and title of certifier 			29c. License number <b>D0015296</b>			29d. Date signed (Month, Day, Year) <b>June 27, 2000</b>																											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Leslie H. Pierce, Jr., M.D., 106 Irving Street, NW, #2500N, Washington, DC 20010</b>																																	
31. Date filed (Month, Day, Year) <b>JUN 27 2000</b>			32. Registrar's Signature 																														

ORIGINAL

81955

2000 1 3 1971

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State of Maryland / Department of Health and Mental Hygiene

00 22219

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert O. Dismuke

2. Date of Death

Month Day Year  
June 25, 2000

3. Time of Death

3:00 am

4a. Facility Name (If not institution, give street and number)

14812 Willoughby Road

4b. City, Town, or Location of Death

Upper Marlboro

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

217-28-8115

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 21, 1934

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

14812 Willoughby Road

10f. Zip Code

20772

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Construction Worker

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Edward James Dismuke

18. Mother's Name (First, Middle, Maiden Surname)

Jessie Gundling

19a. Informant's Name/Relationship (Type, Print)

Ledra M. Dismuke - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14812 Willoughby Road, Upper Marlboro, MD 20772

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

6/28/2000

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gasch's Funeral Home, P.A.  
4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiomyopathy

Due to (or as a consequence of):

b. Renal failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

026190

29d. Date signed (Month, Day, Year)

June 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul L. Siegel 3275 Spirit Lane Bowie

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

00 55518

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22220

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>STEPHEN D. DYKE</b>				2. Date of Death Month <b>JUNE</b> Day <b>22</b> Year <b>2000</b>		3. Time of Death <b>9:46 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>WASHINGTON ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>TAKOMA PARK</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>578-84-4436</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>40</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>AUG. 6, 1959</b>	
	9. Birthplace (State or Foreign Country) <b>IL.</b>		10a. State <b>MD</b>		10b. County <b>MONTGOMERY</b>		10c. City, Town or Location <b>SILVER SPRING</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>13837 TURNMORE ROAD</b>		10f. Zip Code <b>20906</b>		10g. Citizen of What Country? <b>U. S. A.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1 YEAR</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>RECREATION INSTRUCTOR</b>		16b. Kind of Business/Industry <b>RECREATION DEPT.</b>		17. Father's Name (First, Middle, Last) <b>GEORGE D. DYKE</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>BARBARA SIMPSON</b>		19a. Informant's Name/Relationship (Type, Print) <b>BARBARA D. HAWKINS - MOTHER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13837 TURNMORE ROAD SILVER SPRING, MD 20906</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MARYLAND NATIONAL MEMO. PK 6/28/00 LAUREL, MD</b>		20c. Location - City or Town, State		21. Signature of Funeral Service Licensee <b>Theodore C. Pinckney</b>		22. Name and Address of Facility <b>PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH STREET, N. E. WASH., DC 20002</b>		
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): b. <b>CORONARY ARTERY DISEASE</b> Due to (or as a consequence of): c. <b>HYPERLIPIDEMIA</b> Due to (or as a consequence of): d.		23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ESSENTIAL HYPERTENSION</b>		25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>[Signature]</b>		
29c. License number <b>D 51096</b>		29d. Date signed (Month, Day, Year) <b>JUNE 22, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DR. PIOTR WYRWINSKI, 9210 CORPORATE BLVD. #20, ROCKVILLE, MD 20850</b>		31. Date filed (Month, Day, Year) <b>JUN 26 2000</b>		
32. Registrar's Signature <b>[Signature]</b>		33. State Registrar		34. State Registrar		35. State Registrar		

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22221

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EMERSON LAVINE DORSEY

2. Date of Death

JUNE 22 2000

3. Time of Death

8:17 AM

4a. Facility Name (If not institution, give street and number)

FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

FREDERICK

4c. County of Death

Funeral  
Director

5. Social Security Number

218-16-1468

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 11, 1922

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

MD.

10b. County

FREDERICK

10c. City, Town or Location

FREDERICK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4812 TEEN BARNES RD.

10f. Zip Code

21703

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1943-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

BLACK

Specify:

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 YRS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MICROBIOLOGIST

16b. Kind of Business/Industry

RESEARCH GOVT.

17. Father's Name (First, Middle, Last)

EDWARD DORSEY

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE DORSEY

19a. Informant's Name/Relationship (Type, Print)

EMERSON DORSEY, JR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1104 PELHAMWOOD RD. BALT. MD. 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

RESTHAVEN MEM. GAR.

Date

JUNE 26 2000

20c. Location - City or Town, State

FRED MD

21. Signature of Funeral Service Licensee

Gary L. Rollins

22. Name and Address of Facility

GARY L. ROLLINS FUNERAL HOME

110 WEST SOUTH ST FREDERICK MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Approximate Interval Between Onset and Death

30 minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Lung Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Phillip Shapiro

29c. License number

D07186

29d. Date signed (Month, Day, Year)

6/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

814 TOLL HOUSE AVE FRED. MD 21701 Phillip Shapiro

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

B. Shapiro

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-52-2028.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

ORIGINAL



Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Shawn Patrick DeHaven</b>						2. Date of Death Month Day Year <b>JUNE 23, 2000</b>		3. Time of Death <b>02:58 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>I495 OUTER LOOP WEST OF UNIVERSITY BOULEVARD</b>						4b. City, Town, or Location of Death <b>SILVER SPRING</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>213-15-4081</b>		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>17</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 2, 1982</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10e. State <b>Maryland</b>		10b. County <b>Frederick</b>		10c. City, Town or Location <b>Frederick</b>				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>115 Deerfield Place</b>				10f. Zip Code <b>21702</b>		10g. Citizen of What Country? <b>USA</b>			
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>student</b>			16b. Kind of Business/Industry <b>high school</b>				
	17. Father's Name (First, Middle, Last) <b>Brian Thomas DeHaven</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Cheryl Anne Paugh</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Brian DeHaven, father</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>115 Deerfield Place, Frederick, Maryland 21702</b>					
	20e. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. John's Catholic Cem.</b>		Date <b>6/26/2000</b>		20c. Location - City or Town, State <b>Frederick, Maryland</b>			
	21. Signature of Funeral Service Licensee 		M00999		22. Name and Address of Facility <b>Keeney and Basford Funeral Home 106 East Church Street, Frederick, MD 21701</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. <b>Head and chest injuries</b>								Approximate interval between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):									
Division of Vital Records, P.O. Box 68760,	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
									24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.	25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>		26. Place of Death (Check only one)			
	27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>6/23/00</b>		28b. Time of Injury <b>0252 M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Passenger in auto accident</b>	
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JUNE 23, 2000</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. ALLEN LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>									
State Registrar	31. Data filed (Month, Day, Year) <b>JUN 27 2000</b>		32. Registrar's Signature 							

00 55555

00 55555

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22223

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY ANN ACKLEY ELLIOTT

2. Date of Death

Month Day Year  
July 3, 2000

3. Time of Death

0027

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

Funeral  
Director

5. Social Security Number

305-28-4398

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
1/8/1908

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

804 Cedar Street

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Norval Ackley

18. Mother's Name (First, Middle, Maiden Surname)

Eva Whealdon

19a. Informant's Name/Relationship (Type, Print)

Judith Shepardson (niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

207 Payne Ave., Pocomoke City, MD 21851

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mardela Memorial Cemetery

Date

7/7/00

20c. Location - City or Town, State

Mardela Springs, MD

21. Signature of Funeral Service Licensee

Michael A. Dean 101129

22. Name and Address of Facility

Holloway Nelson Funeral Home, P.A.

103 Linden Ave., Pocomoke City, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Liver Metastases

Spinal Stenosis

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ronald P. Trautz

29c. License number

D36576

29d. Date signed (Month, Day, Year)

7/3/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RONALD P. TRAUTZ 560 RIVERSIDE DR Salisbury MD

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 05 2000

32. Registrar's Signature

Ronald P. Trautz

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Dorothy Elliott  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



8833

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 22224**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CYNTHIA FOSTER

2. Date of Death

Month  
06Day  
27Year  
2000

3. Time of Death

125 a.m.

4a. Facility Name (If not institution, give street and number)

CASEY HOUSE MONTGOMERY HOSPICE

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

577-90-7661

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

41

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
10-21-58

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13813 Castle Blvd. Apt. 14

10f. Zip Code

20902

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

NEVER WORKED

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

WILLIE STEVENS

18. Mother's Name (First, Middle, Maiden Surname)

BETTY ALEXANDER

19a. Informant's Name/Relationship (Type, Print)

HAROLD R. FOSTER JR. (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13813 Castle Blvd. Silver Spring, MD. 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

HARMONY MEMORIAL CEMETERY July 05, 2000

Date

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

E. M. DUDLEY

22. Name and Address of Facility

E. M. DUDLEY FUNERAL HOME

20712

3200 RHODE ISLAND AVENUE, MOUNT RAINIER, MD.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Respiratory Failure

Approximate  
Interval Between  
Onset and Death

6 weeks

Due to (or as a consequence of):

Breast Cancer

2 years

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D0054378

6-27-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cheryl A. Alexander 6700 Georgia Ave Wash DC NW 202782 5747

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
20258.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4279



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State of Maryland / Department of Health and Mental Hygiene

00 22225

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Olive Adele Flannery</b>				2. Date of Death Month Day Year <b>June 25 2000</b>		3. Time of Death <b>9:45 p.m.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Doctor's Community Hospital</b>				4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>578-03-0846</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 12, 1917</b>	
	9. Birthplace (State or Foreign Country) <b>Washington, DC</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Riverdale</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>6712 Patterson Street</b>		10f. Zip Code <b>20737</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Secretary</b>		16b. Kind of Business/Industry <b>Plumbers Union</b>		17. Father's Name (First, Middle, Last) <b>William Krug</b>	
	18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Hughes</b>		19a. Informant's Name/Relationship (Type, Print) <b>Barbara Smith - Daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6712 Patterson Street, Riverdale, MD 20737</b>		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery</b>		20c. Date <b>6/28/00</b>		20d. Location - City or Town, State <b>Brentwood, MD</b>		21. Signature of Funeral Service Licensee <b>Claudette Washburn</b>	
	22. Name and Address of Facility <b>Gasch's Funeral Home, P.A.</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Sepsis</b> Due to (or as a consequence of): <b>Vancomycin Resistant Enterococci</b> <b>Congestive Heart Failure</b> Due to (or as a consequence of): <b>Acute Renal Failure</b>		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
	28a. Date of Injury (Month, Day, Year) <b>June 25, 2000</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred	
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) as stated.		29b. Signature and title of certifier <b>Mark Sade, MD</b>	
	29c. License number <b>D050514</b>		29d. Date signed (Month, Day, Year) <b>JUNE 26, 2000</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Mehru Master Sonde 6510 Kenilworth Avenue, #2100, Riverdale, MD 20737</b>		31. Date filed (Month, Day, Year) <b>JUN 28 2000</b>	
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <b>[Signature]</b>		33. Registrar's Signature <b>[Signature]</b>		34. Registrar's Signature <b>[Signature]</b>		35. Registrar's Signature <b>[Signature]</b>	
	36. Registrar's Signature <b>[Signature]</b>		37. Registrar's Signature <b>[Signature]</b>		38. Registrar's Signature <b>[Signature]</b>		39. Registrar's Signature <b>[Signature]</b>	

ORIGINAL

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22226

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>BENJAMIN FRANKLIN FLUCKUS</b>						2. Date of Death Month Day Year <b>June 23 2000</b>		3. Time of Death <b>5:52 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>10211 Buena Vista Avenue</b>						4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>215-38-8993</b>		6. Sex <b>1 M 2 F</b>		7. Age (In yrs. last birthday) <b>87</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Feb. 6, 1913</b>		9. Birthplace (State or Foreign Country) <b>Georgia</b>	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Lanham</b>				10d. Inside City Limits <b>1 Yes 2 No</b>	
	10e. Street and Number <b>10211 Buena Vista Avenue</b>				10f. Zip Code <b>20706</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. Was Decedent Ever in U.S. Armed Forces? <b>1 Yes 2 No</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No) <b>1 Yes 2 No Specify:</b>			14. Race - American Indian, Black, White, etc. <b>Specify: Black</b>		
	15. Decedent's Education (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 1 Year</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Chief Petty Officer</b>				16b. Kind of Business/Industry <b>Government</b>	
	17. Father's Name (First, Middle, Last) <b>Archie Fluckus</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Gohan</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Claudette Fluckus/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10211 Buena Vista Avenue, Lanham, Maryland 20706</b>					
	20a. Method of Disposition <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Arlington National Ceme.</b>		Date <b>07/03 2000</b>		20c. Location - City or Town, State <b>Arlington, Virginia</b>			
	21. Signature of Funeral Service Licensee <b>Nancy A. Pescantie</b>				22. Name and Address of Facility <b>J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metastatic Prostate Cancer</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):									
	Approximate Interval Between Onset and Death <b>5 Years</b>									
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <b>1 Yes 2 No 3 Probably 4 Unknown</b>	
									24a. Was an autopsy performed? <b>1 Yes 2 No</b>	
									24b. Were autopsy findings available prior to completion of cause of death? <b>1 Yes 2 No</b>	
	25. Was case referred to medical examiner? <b>1 Yes 2 No</b>		26. Place of Death (Check only one) Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>							
	27. Manner of Death <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1 Yes 2 No</b>		28d. Describe how injury occurred	
29a. Certifier (Check only one) <b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. Signature and title of certifier <b>John M. Hill, MD, PHYSICIAN</b>								
29c. License number <b>#18870</b>		29d. Date signed (Month, Day, Year) <b>June 23, 2000</b>								
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>John M. Hill, MD, National Naval Medical Center, Bethesda, Maryland</b>										
31. Date filed (Month, Day, Year) <b>JUN 26 2000</b>		32. Registrar's Signature <b>[Signature]</b>								

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22227

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 202-54-2024.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>WALTER FIELDS</b>						2. Date of Death Month Day Year <b>JULY 01 2000</b>		3. Time of Death <b>03:43AM</b>			
4a. Facility Name (If not institution, give street and number) <b>Calvert Memorial Hospital</b>						4b. City, Town, or Location of Death <b>Prince Frederick</b>		4c. County of Death <b>Calvert</b>			
5. Social Security Number <b>216-20-8319</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 31, 1925</b>		9. Birthplace (State or Foreign Country) <b>Maryland</b>			
Usual Residence of Decedent											
10a. State <b>Maryland</b>		10b. County <b>Calvert</b>		10c. City, Town or Location <b>Owings</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
10e. Street and Number <b>8780 Grovers Turn Lane</b>				10f. Zip Code <b>20736</b>		10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>			16b. Kind of Business/Industry <b>Board of Education</b>				
17. Father's Name (First, Middle, Last) <b>Thorton Fields</b>						18. Mother's Name (First, Middle, Maiden Summa) <b>Margaret Robinson</b>					
19a. Informant's Name/Relationship (Type, Print) <b>Bertha Fields/Wife</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 678 Owings, MD 20736</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Calvary United Apost. Chr. 7/5/00</b>		20c. Location - City or Town, State <b>Sunderland, MD</b>					
21. Signature of Funeral Service Licensee <b>Blady A. Sewell</b>						22. Name and Address of Facility <b>Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Cardio - Resp arrest</b> Due to (or as a consequence of): b. <b>aspiration Pneumonia</b> Due to (or as a consequence of): c. <b>massive CVA/stroke</b> Due to (or as a consequence of): d. <b>DM</b>  Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HFN</b> <b>H/O CVA</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
29b. Signature and title of certifier <b>MD</b>				29c. License number <b>D 50290</b>		29d. Date signed (Month, Day, Year) <b>7-1-00</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>DHIREN SHAH, M.D. 110 HOSPITAL RD PRINCE FREDERICK 20678</b>											
31. Date filed (Month, Day, Year) <b>JUL 03 2000</b>				32. Registrar's Signature <b>B. Sparks</b>							

State  
Registrar

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07/1/2000

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State of Maryland / Department of Health and Mental Hygiene 00 22228

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

David Wayne Frye

2. Date of Death

June 29, 2000

3. Time of Death

10:38 A.M.

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

212-62-3060

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

June 6, 1955

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10e. State

Md.

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

119 S. Jefferson Street

10f. Zip Code

21701

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Cement Company

17. Father's Name (First, Middle, Last)

Roy Junior Frye

18. Mother's Name (First, Middle, Maiden Surname)

Doris Lorraine Kroushour

19a. Informant's Name/Relationship (Type, Print)

Doris L. Frye - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

119 S. Jefferson St. - Frederick, MD 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fairview Lutheran Cemetery

Date

7/3/2000

20c. Location - City or Town, State

Bolivar, WV

21. Signature of Funeral Service Licensee

Robert L. Spencer

22. Name and Address of Facility

Eackles-Spencer Funeral Home  
Harpers Ferry, WV 25425

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Adult Respiratory Distress Syndrome days

Due to (or as a consequence of):

Sepsis

Due to (or as a consequence of):

Peritonitis

Due to (or as a consequence of):

Incarcerated Hernia

Approximate Interval Between Onset and Death

Physician  
/Medical  
Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cor pulmonale  
obesity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert L. Spencer

29c. License number

D26576

29d. Date signed (Month, Day, Year)

July 1 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Aileen S. Gotsow 1475 TANEY AVE FRED MD 21702

31. Date filed (Month, Day, Year)

JUL 01 2000

32. Registrar's Signature

Robert L. Spencer

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22229

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DONNA LISA BENTLEY GRAY

2. Date of Death

6/21/2000

3. Time of Death

9:00pm

4a. Facility Name (If not institution, give street and number)

DOCTORS HOSPITAL

4b. City, Town, or Location of Death

LANHAM

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

042 48 5240

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

41

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 28, 1959

9. Birthplace (State or Foreign Country)

BRIDGEPORT CONN

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

UPPER MARLBORO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

76 JOYCETON WAY

10f. Zip Code

20774

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

ACCOUNTANT

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

CARL W. BENTLEY

18. Mother's Name (First, Middle, Maiden Surname)

GRACE V. GRIER

19a. Informant's Name/Relationship (Type, Print)

ROY V. GRAY HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

76 JOYCETON WAY UPPER MARLBORO MD. 20774

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

RESURRECTION CEMETERY

Date

6/29/00

20c. Location - City or Town, State

CLINTON MD.

21. Signature of Funeral Service Licensee

Kurt A. Lange M1055

22. Name and Address of Facility

POPE FUNERAL HOME, 5538 MARLBORO PIKE FORESTVILLE  
MD. 2074723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Myocardial Infarction  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

30 minutes

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William F. DuBoyce

29c. License number

047603

29d. Date signed (Month, Day, Year)

06/28/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

William F. DuBoyce, M.D. 4000 Mitchellville Rd. S-B216 Bowie, Md. 20716

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

William F. DuBoyce

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Handwritten signature or scribble

0005 0 8 100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22230

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

June V. Gallahan

2. Date of Death

June 22, 2000

3. Time of Death

8:10AM

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital Center

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

033-18-4249

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 16, 1924

9. Birthplace (State or Foreign Country)

Arlington, Mass.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12323 Piscataway Road

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No WWII

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Asst. Lot Foreman

16b. Kind of Business/Industry

Board of Ed.P.G. Co.

17. Father's Name (First, Middle, Last)

Robert Henderson Little

18. Mother's Name (First, Middle, Maiden Surname)

Mechtilde Veronica Donovan

19a. Informant's Name/Relationship (Type, Print)

John Gallahan/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13105 Larkhall Circle Ft. Washington, Md. 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Church Cem. 6/26/2000

Date

20c. Location - City or Town, State

Clinton, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home, P.A.

6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Pert. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accidents

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Prosthetic mitral valve

Due to (or as a consequence of):

9 years

c. atrial fibrillation

Due to (or as a consequence of):

chronic

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D13072

29d. Date signed (Month, Day, Year)

6-22-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gurbux Nachnani, M.D. 8926 Woodyard Rd. Clinton, Md. 20735

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Important: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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000000 000000 000000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22231

## Certificate of Death

Reg. No.

|                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                 |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                  |  |
|---------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>HELEN JEANNETTE GRAY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                 |                                                                                                                                                   |  | 2. Date of Death<br>Month Day Year<br><b>June 23, 2000</b>                                                                                                                                                                                                                                  |  | 3. Time of Death<br><b>8:00AM</b>                                                |  |
|                                                         | 4a. Facility Name (If not institution, give street and number)<br><b>Crescent Cities Center-Genesis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                 |                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br><b>Riverdale</b>                                                                                                                                                                                                                                    |  | 4c. County of Death<br><b>Prince Georges</b>                                     |  |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>217-32-3340</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                 | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.                                                                                                                                                                                                                                            |  | 8. Date of Birth (Month, Day, Year)<br><b>10-08-1934</b>                         |  |
|                                                         | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                 | 10a. State<br><b>Maryland</b>                                                                                                                     |  | 10b. County<br><b>Prince Georges</b>                                                                                                                                                                                                                                                        |  | 10c. City, Town or Location<br><b>Forestville</b>                                |  |
| To Be Completed by Funeral Director                     | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                 | 10e. Street and Number<br><b>8109 Richard Drive</b>                                                                                               |  | 10f. Zip Code<br><b>20747</b>                                                                                                                                                                                                                                                               |  | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |
|                                                         | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                     |                                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>          |  |
|                                                         | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nursing Assistant</b>             |  | 16b. Kind of Business/Industry<br><b>Hospital - Nursing</b>                                                                                                                                                                                                                                 |  |                                                                                  |  |
|                                                         | 17. Father's Name (First, Middle, Last)<br><b>Robert R. Gray</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                 |                                                                                                                                                   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rebecca Bowie</b>                                                                                                                                                                                                                   |  |                                                                                  |  |
|                                                         | 19a. Informant's Name/Relationship (Type, Print)<br><b>Varneise Jones</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                 |                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8109 Richard Drive, Forestville, MD 20747</b>                                                                                                                                           |  |                                                                                  |  |
|                                                         | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                              |                                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resurrection Cemetery</b>                                            |  | 20c. Date<br><b>06-27-00</b>                                                                                                                                                                                                                                                                |  | 20d. Location - City or Town, State<br><b>Clinton, MD</b>                        |  |
|                                                         | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                 |                                                                                                                                                   |  | 22. Name and Address of Facility<br><b>Strickland Funeral Services, P.A.<br/>6500 Allentown Road, Camp Springs, MD 20748</b>                                                                                                                                                                |  |                                                                                  |  |
|                                                         | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. c. d.</b><br>Due to (or as a consequence of): |                                                 |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                  |  |
|                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                   |                                                 |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                  |  |
|                                                         | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                   |                                                 |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                  |  |
| Physician<br>/Medical<br>Examiner                       | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                 |                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                  |  |
|                                                         | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                      |                                                 | 28a. Date of Injury (Month, Day, Year)                                                                                                            |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                             |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|                                                         | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                 | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                                            |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |  |                                                                                  |  |
|                                                         | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                          |                                                 |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                  |  |
| State<br>Registrar                                      | 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                 |                                                                                                                                                   |  | 29c. License number<br><b>101852</b>                                                                                                                                                                                                                                                        |  | 29d. Date signed (Month, Day, Year)<br><b>JUNE 26, 2000</b>                      |  |
|                                                         | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>PAUL A. DEVORE, MD 4203 QUEENSBURY Rd HYATTSVILLE MD 20781</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                 |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 27 2000</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 32. Registrar's Signature<br><i>[Signature]</i> |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                  |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22232

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ERIC JACK GAINOUS

2. Date of Death

Month Day Year  
June 20, 2000

3. Time of Death

10:57PM

4a. Facility Name (If not institution, give street and number)

Doctors Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

578-70-8721

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

47yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
09-25-52

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Clinton

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

12607 Lunan Drive

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Trucking

17. Father's Name (First, Middle, Last)

Jerald Gainous

18. Mother's Name (First, Middle, Maiden Surname)

Maryam Muhammad

19a. Informant's Name/Relationship (Type, Print)

Veronique Taylor-Gainous

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12607 Lunan Drive, Clinton, MD 20735

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Chesapeake Crematory

Date

06-26-00

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

*Eric J. Strickland*

22. Name and Address of Facility

Strickland Funeral Services, PA  
6500 Allentown Road, Camp Springs, Maryland 2074823. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Carcinoma of the

Due to (or as a consequence of):

b. Pancreas with Liver and bone

Due to (or as a consequence of):

c. mets

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

2 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Sajeew Anand, M.D.*

29c. License number

D-33482

29d. Date signed (Month, Day, Year)

June 27, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*Sajeew Anand, M.D. 7343A Hanover parkway, Greenbelt, Md 20770*

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

*[Signature]*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
0202.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



100-1-100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22233

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br>Robert B. Ganey                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      | 2. Date of Death<br>Month Day Year<br>June 25, 2000                                  |                                                                  | 3. Time of Death<br>7:05 AM                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br>Mariners Health Care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      | 4b. City, Town, or Location of Death<br>Silver Spring                                |                                                                  | 4c. County of Death<br>Montgomery                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br>578-34-8974                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                             |                               | 7. Age (In yrs. last birthday)<br>71 Yrs.                                                                                                                                                           |                                                      | 8. Date of Birth (Month, Day, Year)<br>Nov. 3, 1928                                  |                                                                  | 9. Birthplace (State or Foreign Country)<br>Washington, D.C.                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                              | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. County<br>Prince Georges                                                                                                                              |                               | 10c. City, Town or Location<br>Hyattsville                                                                                                                                                          |                                                      |                                                                                      |                                                                  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10e. Street and Number<br>4922 40th. Place                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                            |                               | 10f. Zip Code<br>20781                                                                                                                                                                              |                                                      | 10g. Citizen of What Country?<br>U.S.A.                                              |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1947 |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                      |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                            |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Construction Engineer                                                                  |                                                      |                                                                                      | 16b. Kind of Business/Industry<br>Tri-County Industries          |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. Father's Name (First, Middle, Last)<br>Lee Ganey                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br>Inez Banta                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 19a. Informant's Name/Relationship (Type, Print)<br>Jacqueline L. Ganey (Wife)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                            |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4922 40th. Place Hyattsville, MD 20781                                                             |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Cemtery                                                             |                               | 20c. Location - City or Town, State<br>6/28/00 Brentwood, Maryland                                                                                                                                  |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                            |                               | 22. Name and Address of Facility<br>Rendon/Hale Funeral Home<br>9013 Annapolis Rd. Lanham, Maryland 20706                                                                                           |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Pneumonia<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                             | Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br>Cerebrovascular Disease                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                 |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                     |                               | 28b. Time of Injury<br>M                                                                                                                                                                            |                                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                            |                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                        |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                            | 29c. License number<br>D09834 |                                                                                                                                                                                                     | 29d. Date signed (Month, Day, Year)<br>June 26, 2000 |                                                                                      |                                                                  |                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Barry N. Rosenbaum M.D. 3720 Farragut Ave. Kensington, MD 20895-2110                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br>JUN 26 2000                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      |                                                                                      |                                                                  |                                                                                                    |  |
| 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                            |                               |                                                                                                                                                                                                     |                                                      |                                                                                      |                                                                  |                                                                                                    |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

MDO G/85

7-28-00 WR.

00 22234

AMEND ITEMS: 23 PART I, 11, 27, 28A-F PER

Certificate of Death

Reg. No.

|                                     |                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                             |  |                                                                                                                                                    |  |
|-------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JUAN M. GORDON</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  | 2. Date of Death<br>Month Day Year<br><b>June 29, 2000</b>                                                                                                                                                                                                                                  |  |                                                                                             |  | 3. Time of Death<br><b>1835 pm</b>                                                                                                                 |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>                                                                                                                                                                                                                             |  |                                                                                             |  | 4c. County of Death<br><b>Calvert</b>                                                                                                              |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>577-74-4395</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>45</b> Yrs.                                                                                                                                                                                                                                            |  | If Under 1 Year<br>Months Days                                                              |  | If Under 24 Hrs.<br>Hours Min.                                                                                                                     |  |
|                                     | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 12, 1954</b>                                                                                                                                                                                                                                                                                                                                                               |  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>                                                                                 |  | 10a. State                                                                                                                                                                                                                                                                                  |  | 10b. County                                                                                 |  | 10c. City, Town or Location<br><b>Washington, DC</b>                                                                                               |  |
| To Be Completed by Funeral Director | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |  | 10e. Street and Number<br><b>3790 Martin Luther King JR. Ave. APT. #3B</b>                                                                        |  | 10f. Zip Code<br><b>20032</b>                                                                                                                                                                                                                                                               |  | 10g. Citizen of What Country?<br><b>United States of America</b>                            |  |                                                                                                                                                    |  |
|                                     | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                            |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |                                                                                                                                                    |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b>                                                                                                                                                                                                                                                                                                          |  | College (14 or 5+)                                                                                                                                |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cable Installation</b>                                                                                                                                                      |  | 16b. Kind of Business/Industry<br><b>Private Industry</b>                                   |  |                                                                                                                                                    |  |
|                                     | 17. Father's Name (First, Middle, Last)<br><b>Robert Gordon</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gwendolyn Fisher</b>                                                                                                                                                                                                                |  |                                                                                             |  |                                                                                                                                                    |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gwendolyn Fisher/Mother</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3790 Martin Luther King Jr. AVE S.E. WDC 20032</b>                                                                                                                                      |  |                                                                                             |  |                                                                                                                                                    |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glenwood Cemetery</b>                                                |  | Date<br><b>7/7/2000</b>                                                                                                                                                                                                                                                                     |  | 20c. Location - City or Town, State<br><b>Washington, D.C.</b>                              |  |                                                                                                                                                    |  |
|                                     | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |  | 22. Name and Address of Facility<br><b>Johnson &amp; Jenkins Funeral Home</b><br><b>716 Kennedy ST NW WDC 20011</b>                                                                                                                                                                         |  |                                                                                             |  |                                                                                                                                                    |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>LEPTOMENINGITIS WITH CEREBRAL CORTICAL INFARCTION</b>                                                                                                                                                     |  |                                                                                                                                                   |  | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                |  |                                                                                             |  |                                                                                                                                                    |  |
|                                     | b. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                             |  |                                                                                                                                                    |  |
|                                     | c. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                             |  |                                                                                                                                                    |  |
| d. Due to (or as a consequence of): |                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                             |  |                                                                                                                                                    |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DILATED CARDIOMYOPATHY; NARCOTIC ABUSE</b>                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |  |                                                                                             |  |                                                                                                                                                    |  |
|                                     |                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                       |  |                                                                                             |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|                                     | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                             |  |                                                                                                                                                    |  |
|                                     | 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                    |  | 28a. Date of Injury (Month, Day, Year)<br><b>UNKNOWN</b>                                                                                          |  | 28b. Time of Injury<br><b>UNKNOWN</b>                                                                                                                                                                                                                                                       |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>UNKNOWN</b>                                                                                                |  |
|                                     |                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>UNKNOWN</b>                                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>UNKNOWN</b>                                                                                                                                                                                              |  |                                                                                             |  |                                                                                                                                                    |  |
|                                     | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                                                                                                                                   |  | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                   |  |                                                                                             |  | 29c. License number<br><b>O.C.M.E.</b>                                                                                                             |  |
|                                     |                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  | 29d. Date signed (Month, Day, Year)<br><b>June 30, 2000</b>                                                                                                                                                                                                                                 |  |                                                                                             |  |                                                                                                                                                    |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. LARON WICKS, MD</b>                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  | <b>111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                           |  |                                                                                             |  |                                                                                                                                                    |  |
|                                     | 31. Date filed (Month, Day, Year)<br><b>JUL 06 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |  |                                                                                             |  |                                                                                                                                                    |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22235

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EVALYN K. GRENING

2. Date of Death

June 20

Day

2000

Year

3. Time of Death

1750

4a. Facility Name (If not institution, give street and number)

Memorial Hospital Easton

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

172-03-9875

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT. 3, 1910

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

PA

10b. County

SOMERSET

10c. City, Town or Location

CONEMAUGH

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3010 SOMERSET PIKE

10f. Zip Code

15905

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

OFFICE WORKER

16b. Kind of Business/Industry

MANUFACTURING

17. Father's Name (First, Middle, Last)

DAVID KAUFMAN

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE RISH

19a. Informant's Name/Relationship (Type, Print)

KEVIN PILE/TRUST OFFICER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

551 MAIN ST. JOHNSTOWN, PA 15901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

RICHLAND CEMETERY

Date

6-24-00

20c. Location - City or Town, State

JOHNSTOWN, PA

21. Signature of Funeral Service Licensee

M. B. Boehmer

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA  
200 S. HARRISON ST EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Breast CANCER

b.

Due to (or as a consequence of):

Hypertension

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

yrs.  
yrs.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David Boehmer

29c. License number

H0053459

29d. Date signed (Month, Day, Year)

6/20/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID BOEHMER, M.D. 219 S. WASHINGTON ST., EASTON, MD 21601

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

G. Sparks

Evalyn Grening  
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

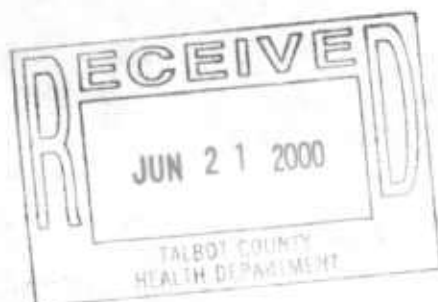
To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22236

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vivian Grace Hee

2. Date of Death

Month Day Year  
June 28 2000

3. Time of Death

3:20 A.M.

4a. Facility Name (If not institution, give street and number)

Asbury Methodist Village Nursing Home

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

213 38 4352

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 11, 1919

9. Birthplace (State or Foreign Country)

North Dakota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

301 Russell Ave. No. 215A

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Service Representative

16b. Kind of Business/Industry

Prince George's Hospital

17. Father's Name (First, Middle, Last)

Victor Esson

18. Mother's Name (First, Middle, Maiden Surname)

Sophie Margaret Hatalie

19a. Informant's Name/Relationship (Type, Print)

Beverly J. Krakat Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15521 Eagle Tavern Lane Centreville VA 20120

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

June 29, 2000

20c. Location - City or Town, State

Alexandria Virginia

21. Signature of Funeral Service Licensee

Robert E. Evans

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Chronic renal failure

weeks

Due to (or as a consequence of):

b.

Insulin Dependent Diabetes Mellitus

years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ellen M Pinholt MD

29c. License number

D51015

29d. Date signed (Month, Day, Year)

June 29, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Ellen Pinholt MD 5530 Wisconsin Ave #1045 Chevy Chase, MD 20815

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

B. B. B. B.

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

25



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State of Maryland / Department of Health and Mental Hygiene

00 22237

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                   |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br><b>Raymond Hall</b>                                         |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month <b>June</b> Day <b>22</b> Year <b>2000</b> |                                                                                             |                                                                 |                                                                                                                                                                                                  | 3. Time of Death<br><b>4:20 P.M.</b>                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4e. Facility Name (If not institution, give street and number)<br><b>Spa Creek Genesis Elderly Care</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Annapolis</b>             |                                                                                             |                                                                 |                                                                                                                                                                                                  | 4c. County of Death<br><b>Anne Arundel</b>                        |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5. Social Security Number<br><b>579-14-0735</b>                                                         |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                     |                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>November 11, 1920</b> |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Usual Residence of Decedent                                                                             |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                   |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         | 10b. County<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                          |                                                                            | 10c. City, Town or Location<br><b>Annapolis</b>                                                                                                                                              |                                                                      |                                                                                             |                                                                 | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |                                                                   |  |
| 10e. Street and Number<br><b>35 Milkshake Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            | 10f. Zip Code<br><b>21403</b>                                                                                                                                                                |                                                                      | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                              |                                                                 |                                                                                                                                                                                                  |                                                                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                      |                                                                                             |                                                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                                                                                                                          |                                                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Boat Mechanic</b>                                                            |                                                                      |                                                                                             |                                                                 | 16b. Kind of Business/Industry<br><b>Marina</b>                                                                                                                                                  |                                                                   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Roland Hall</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Georgianna Lamb</b>                                                                                                                  |                                                                      |                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Bonnie Griffin / Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8204 Woburn Abbey Rd. Glendale, MD 20769</b>                                             |                                                                      |                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery</b>                                                                                                                                                                                       |                                                                            | Date<br><b>June 26, 2000</b>                                                                                                                                                                 |                                                                      | 20c. Location - City or Town, State<br><b>Brentwood, MD</b>                                 |                                                                 |                                                                                                                                                                                                  |                                                                   |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>Ft. Lincoln Funeral Home</b><br><b>3401 Bladensburg Rd. Brentwood, MD 20722</b>                                                                       |                                                                      |                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Pulmonary embolus</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>renal insufficiency</b><br><b>congestive heart failure</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                             |                                                                 | Approximate Interval Between Onset and Death<br><b>1 day</b>                                                                                                                                     |                                                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>renal insufficiency</b><br><b>congestive heart failure</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                             |                                                                 | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                 | 28d. Describe how injury occurred                                                                                                                                                                |                                                                   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                                      |                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                               |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                             |                                                                 | 29c. License number<br><b>D32036</b>                                                                                                                                                             |                                                                   |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            | 29d. Date signed (Month, Day, Year)<br><b>6/24/2000</b>                                                                                                                                      |                                                                      |                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                   |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Gary J. Sprase 2108 D. Drive Chester, MD 21619</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 29 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         | 32. Registrar's Signature<br>                                                                                                                                                                            |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                   |  |

ORIGINAL

0005 12 3 HUI

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State of Maryland / Department of Health and Mental Hygiene

00 22238

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                            |  |                                                                                                                                                                                                  |  |                                                             |  |                                                                                                                                                                                                                                                                                                          |  |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>John Hlavay</b>                                                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 2. Date of Death<br>Month Day Year<br><b>June 22, 2000</b>                                                                                                                                       |  |                                                             |  | 3. Time of Death<br><b>12:55 AM</b>                                                                                                                                                                                                                                                                      |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>Southern Maryland Hospital</b>                                                                                                                                                                                                                                                                                                                       |  |                                                                            |  | 4b. City, Town, or Location of Death<br><b>Clinton</b>                                                                                                                                           |  |                                                             |  | 4c. County of Death<br><b>Prince Georges</b>                                                                                                                                                                                                                                                             |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>185-12-1738</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>77</b>                                                                                                                                                      |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 13, 1922</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>                                                                                                                                                                                                                                                  |  |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 10a. State<br><b>Maryland</b>                                                                                                                                                                    |  | 10b. County<br><b>Prince Georges</b>                        |  | 10c. City, Town or Location<br><b>Capital Heights</b>                                                                                                                                                                                                                                                    |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |  |                                                                            |  | 10e. Street and Number<br><b>908 Mentor Avenue</b>                                                                                                                                               |  |                                                             |  | 10f. Zip Code<br><b>20743</b>                                                                                                                                                                                                                                                                            |  |
|                                               | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                   |  |                                                             |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                       |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                              |  |                                                                            |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                          |  |                                                             |  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>                                                                                                                                                                                                    |  |
|                                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mechanic</b>                                                                                                                                                                                                                                                                                              |  |                                                                            |  | 16b. Kind of Business/Industry<br><b>U.S. Postal Service</b>                                                                                                                                     |  |                                                             |  | 17. Father's Name (First, Middle, Last)<br><b>Andrew Hlavay</b>                                                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Capatin</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                            |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Peter J. Hlavay (Brother)</b>                                                                                                             |  |                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1921 Kirkby Dr. South Park, Pa. 15129</b>                                                                                                                                                            |  |
|                                               | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |  |                                                                            |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>                                                                                             |  |                                                             |  | 20c. Location - City or Town, State<br><b>6-27-00 Suitland, Maryland</b>                                                                                                                                                                                                                                 |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 22. Name and Address of Facility<br><b>Lee F.H. Inc.</b>                                                                                                                                         |  |                                                             |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cellulitis</b><br>Due to (or as a consequence of):<br><b>Peripheral Vascular Disease</b> |  |
|                                               | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart failure</b><br><b>Diabetes Mellitus, type 2</b>                                                                                                                                                                                                                        |  |                                                                            |  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |                                                             |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                        |  |                                                                            |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                |  |                                                             |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)              |  |
|                                               | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                 |  |                                                                            |  | 28a. Date of Injury (Month, Day, Year)<br><b>6/27/00</b>                                                                                                                                         |  |                                                             |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |  |                                                                            |  | 28d. Describe how injury occurred                                                                                                                                                                |  |                                                             |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                             |  |
|                                               | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                                                            |  | 29b. Signature and title of certifier<br>                                                                                                                                                        |  |                                                             |  | 29c. License number<br><b>D00 52741</b>                                                                                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner | 29d. Date signed (Month, Day, Year)<br><b>6/27/00</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                            |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Caroline Caine MD 9131 Piscataway Road #600 Clinton MD 20735</b>                                      |  |                                                             |  | 31. Date filed (Month, Day, Year)<br><b>JUN 28 2000</b>                                                                                                                                                                                                                                                  |  |
|                                               | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                            |  | 33. State Registrar<br><b>State Registrar</b>                                                                                                                                                    |  |                                                             |  | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020                                                                                                                                                                                                                            |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 22239

|                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                                                   |                                 |                                                                                                                                                                                               |                                                                                                |                                                                         |                                                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                           | 1. Decedent's Name (First, Middle, Last)<br><b>Mary O'Brien Higgins</b>                                                                                                                                                               |                                                                                                                                                       |                                                                                                                                                   |                                 | 2. Date of Death<br>Month Day Year<br><b>June 23, 2000</b>                                                                                                                                    |                                                                                                | 3. Time of Death<br><b>5:00AM</b>                                       |                                                                              |  |
|                                                                                                                                                                                                                                                                                             | 4a. Facility Name (If not institution, give street and number)<br><b>Bradford Oaks Nursing Home</b>                                                                                                                                   |                                                                                                                                                       |                                                                                                                                                   |                                 | 4b. City, Town, or Location of Death<br><b>Clinton</b>                                                                                                                                        |                                                                                                | 4c. County of Death<br><b>Prince George</b>                             |                                                                              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                         | 5. Social Security Number<br><b>107-10-7119</b>                                                                                                                                                                                       | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                            | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.                                                                                                  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                | 8. Date of Birth (Month, Day, Year)<br><b>July 31, 1917</b>                                    |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>New York</b>                  |  |
|                                                                                                                                                                                                                                                                                             | Usual Residence of Decedent                                                                                                                                                                                                           |                                                                                                                                                       |                                                                                                                                                   |                                 |                                                                                                                                                                                               |                                                                                                |                                                                         |                                                                              |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                         | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                         | 10b. County<br><b>Prince George</b>                                                                                                                   | 10c. City, Town or Location<br><b>Upper Marlboro</b>                                                                                              |                                 |                                                                                                                                                                                               | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                         |                                                                              |  |
|                                                                                                                                                                                                                                                                                             | 10e. Street and Number<br><b>6824 Carroll Way</b>                                                                                                                                                                                     |                                                                                                                                                       |                                                                                                                                                   | 10f. Zip Code<br><b>20772</b>   |                                                                                                                                                                                               | 10g. Citizen of What Country?<br><b>United States</b>                                          |                                                                         |                                                                              |  |
|                                                                                                                                                                                                                                                                                             | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                        |                                                                                                                                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                              |  |
|                                                                                                                                                                                                                                                                                             | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>                                                                                                  |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>                     |                                 | 16b. Kind of Business/Industry<br><b>New York State Government</b>                                                                                                                            |                                                                                                |                                                                         |                                                                              |  |
|                                                                                                                                                                                                                                                                                             | 17. Father's Name (First, Middle, Last)<br><b>Patrick O'Brien</b>                                                                                                                                                                     |                                                                                                                                                       |                                                                                                                                                   |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma Call</b>                                                                                                                         |                                                                                                |                                                                         |                                                                              |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                               | 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia Higgins/ Daughter</b>                                                                                                                                                 |                                                                                                                                                       |                                                                                                                                                   |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6824 Carroll Way Upper Marlboro, Md. 20772</b>                                            |                                                                                                |                                                                         |                                                                              |  |
|                                                                                                                                                                                                                                                                                             | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |                                                                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holy Name Church Cemetery</b>                                        |                                 | 20c. Date<br><b>6/29</b>                                                                                                                                                                      |                                                                                                | 20d. Location - City or Town, State<br><b>AuSable, N.Y.</b>             |                                                                              |  |
|                                                                                                                                                                                                                                                                                             | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                   |                                 | 22. Name and Address of Facility<br><b>Lee Funeral Home, INC.<br/>6633 Old Alexander Ferry Rd. Clinton, Md. 20735</b>                                                                         |                                                                                                |                                                                         |                                                                              |  |
|                                                                                                                                                                                                                                                                                             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |                                                                                                                                                       |                                                                                                                                                   |                                 |                                                                                                                                                                                               |                                                                                                |                                                                         |                                                                              |  |
|                                                                                                                                                                                                                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |                                                                                                                                                       |                                                                                                                                                   |                                 |                                                                                                                                                                                               |                                                                                                |                                                                         |                                                                              |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                       |                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                                                   |                                 |                                                                                                                                                                                               |                                                                                                |                                                                         |                                                                              |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                                                   |                                 |                                                                                                                                                                                               |                                                                                                |                                                                         |                                                                              |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                           |                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                                                   |                                 |                                                                                                                                                                                               |                                                                                                |                                                                         |                                                                              |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                                                       |                                                                                                                                                       |                                                                                                                                                   |                                 |                                                                                                                                                                                               |                                                                                                |                                                                         |                                                                              |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                |                                                                                                                                                                                                                                       | 28a. Date of Injury (Month, Day Year)                                                                                                                 |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b> |                                                                                                                                                                                               | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |                                                                         | 28d. Describe how Injury occurred                                            |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner                                                                                                                                                                                                     |                                                                                                                                                                                                                                       | 29b. Signature and title of certifier<br>                                                                                                             |                                                                                                                                                   |                                 |                                                                                                                                                                                               |                                                                                                |                                                                         | 29c. License number<br><b>D-44436</b>                                        |  |
| 29d. Date signed (Month, Day, Year)<br><b>JUNE 23 '2000</b>                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                       | 29e. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ASHVINKUMAR J PATEL 6B PRISTON SQ II WARDORF MD 20602</b> |                                                                                                                                                   |                                 |                                                                                                                                                                                               |                                                                                                |                                                                         | 29f. Location (Street and Number or Rural Route Number, City or Town, State) |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)                                                                                                                                                                                                        |                                                                                                                                                                                                                                       | 31. Data filed (Month, Day, Year)<br><b>JUN 27 2000</b>                                                                                               |                                                                                                                                                   |                                 |                                                                                                                                                                                               |                                                                                                |                                                                         | 32. Registrar's Signature<br>                                                |  |



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 22240

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VERONICA HICKERSON

2. Date of Death

Month Day Year  
JUNE 21 2000

3. Time of Death

0845AM

4a. Facility Name (If not institution, give street and number)

St. Agnes Health Care

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

577-72-9868

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 3, 1954

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8706 Maple Street

10f. Zip Code

20715

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Data Engrtry Clerk

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Charles Hickerson

18. Mother's Name (First, Middle, Maiden Surname)

Gardenia Cooper

19a. Informant's Name/Relationship (Type, Print)

Tarita Hickerson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5601 Parker House Terrace, #308, Hyattsville, MD 20782

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

06/27 2000

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perentie

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME  
7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Failure

Due to (or as a consequence of):

b. pulmonary thromboembolism

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

< 1 day

< 7 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pulmonary hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

26. Place of Death (Check only one)

27. Manner of Death

1 ☐ Natural

5 ☐ Pending investigation

2 ☐ Accident

6 ☐ Could not be determined

3 ☐ Suicide

4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

M.D.

29c. License number

MD 54343

29d. Date signed (Month, Day, Year)

June 22, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Christian H. Hansen M.D. STAGNES HEALTHCARE  
900 CATON AVE BALTIMORE, MD 21229

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

[Signature]

State Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

NAME

VERONICA A. HICKERSON

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

00 22241

amend item 1, 4a, per me G786 8/16/00 yg

## Certificate of Death

Reg. No. \_\_\_\_\_

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                |                                                                                             |                                                              |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Goldie Glen HALEY</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                | 2. Date of Death<br>Month Day Year<br><b>JUNE 13 2000</b>                                   |                                                              | 3. Time of Death<br><b>17:00 PM</b>                                                            |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>2107 HARWOOD ROAD 2107 Harwood Court</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                | 4b. City, Town, or Location of Death<br><b>DISTRICT HEIGHTS</b>                             |                                                              | 4c. County of Death<br><b>PRINCE GEORGE'S</b>                                                  |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>579 42 5007</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                               |                                                                                                         | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.                                                                                                                                              |                                                                                                                                                | 8. Date of Birth (Month, Day, Year)<br><b>12-4-1933</b>                                     |                                                              | 9. Birthplace (State or Foreign Country)<br><b>VA</b>                                          |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                |                                                                                             |                                                              |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                        | 10b. County<br><b>Prince George's</b>                                                                                                                                                                                                                                                                    |                                                                                                         | 10c. City, Town or Location<br><b>District Heights</b>                                                                                                                                        |                                                                                                                                                |                                                                                             |                                                              | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>2107 Harwood Ct.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                        |                                                                                                                                                                                                                                                                                                          |                                                                                                         | 10f. Zip Code<br><b>20747</b>                                                                                                                                                                 |                                                                                                                                                | 10g. Citizen of What Country?<br><b>USA</b>                                                 |                                                              |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                     |                                                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1956-58</b>                                                                                                                                         |                                                                                                         | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                     |                                                              |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) _____                                                                                                                                                                                                                                                                                                                                              |                                                                                        | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>plumber</b>                                                                                                                                                                              |                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                | 16b. Kind of Business/Industry<br><b>plumbing</b>                                           |                                                              |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 17. Father's Name (First, Middle, Last)<br><b>Warden Haley, Sr.</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pauline Haley</b>                                                                      |                                                                                             |                                                              |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Darlene DePhillip (daug.)</b>                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9031 Tonya's Terrace, Owings, MD 20736</b> |                                                                                             |                                                              |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                                                                                                                                                                                                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b> |                                                                                                                                                                                               | Date<br><b>6-15-00</b>                                                                                                                         |                                                                                             | 20c. Location - City or Town, State<br><b>Alexandria, VA</b> |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 21. Signature of Funeral Service Licensed<br>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                               | 22. Name and Address of Facility<br><b>Rausch Funeral Home, Owings, MD 20736</b>                                                               |                                                                                             |                                                              |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Seizure Disorder</b><br>Due to (or as a consequence of):<br>b. <b>Chronic Alcoholism</b><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____ |                                                                                        |                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                |                                                                                             |                                                              |                                                                                                |  | Approximate Interval Between Onset and Death                                                                                                                                                     |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                             |                                                                                        |                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                |                                                                                             |                                                              |                                                                                                |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                |                                                                                             |                                                              |                                                                                                |  | 24a. Was an autopsy performed?<br><b>partial</b><br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                          |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                  |                                                                                        | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                |                                                                                             |                                                              |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                      |                                                                                        | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                    |                                                                                                         | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |                                                                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                              | 28d. Describe how injury occurred                                                              |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                   |                                                                                             |                                                              |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                |                                                                                             |                                                              |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                               | 29c. License number<br><b>O.C.M.E.</b>                                                                                                         |                                                                                             | 29d. Date signed (Month, Day, Year)<br><b>JUNE 14, 2000</b>  |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chuteau 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                |                                                                                             |                                                              |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                           | 31. Date filed (Month, Day, Year)<br><b>JUN 19 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                        | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                            |                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                |                                                                                             |                                                              |                                                                                                |  |                                                                                                                                                                                                  |  |                                                                                                                                                    |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22242

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LUDWIG HEDDERICH

2. Date of Death

Month Day Year  
06 27 2000

3. Time of Death

2:55 p.m.

4a. Facility Name (If not institution, give street and number)

Caroline Nursing Home

4b. City, Town, or Location of Death

Denton

4c. County of Death

Caroline

Funeral  
Director

5. Social Security Number

216-07-7842

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
NOV. 13, 1909

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

CAROLINE

10c. City, Town or Location

DENTON

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

520 KERR AVENUE

10f. Zip Code

21629

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

3

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LOCOMOTIVE ENGINEER

16b. Kind of Business/Industry

RAILROAD

17. Father's Name (First, Middle, Last)

PHILLIP HEDDERICH

18. Mother's Name (First, Middle, Maiden Surname)

KATHARINE SCHMIDT

19a. Informant's Name/Relationship (Type, Print)

DR. RONALD L. HEDDERICH/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1006 HILLENDALE ROAD, GRAY, TN 37615

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

WOODLAWN MEMORIAL PARK

Date

7-01-00

20c. Location - City or Town, State

EASTON, MD

21. Signature of Funeral Service Licensee

Maurice E. New # CKSP

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME, PA  
200 S. HARRISON ST. EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive heart Failure

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension  
Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Sikes MD

29c. License number

D 31376

29d. Date signed (Month, Day, Year)

6-27-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Sikes 920 Market ST Denton MD 21629

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

B. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-3000.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22243

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                               |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>CLARENCE E. HARTLEY Jr.</b>                                                                                                                                                                                                                                                                                                                                                |                                                                            | 2. Date of Death<br>Month <b>June</b> Day <b>30</b> Year <b>2000</b>                                                                                                                                                                                                                        |                                                            | 3. Time of Death<br><b>3:06 AM</b>                                                                                                                                                            |                                              |
| 4a. Facility Name (If not institution, give street and number)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                                                                                                                                                                               | 4c. County of Death<br><b>Baltimore City</b> |
| 5. Social Security Number<br><b>230-24-0198</b>                                                                                                                                                                                                                                                                                                                                                                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.                                                                                                                                                                                                                                            | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 2, 1926</b> | 9. Birthplace (State or Foreign Country)<br><b>D.C.</b>                                                                                                                                       |                                              |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                               |                                              |
| 10a. State<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                  | 10b. County<br><b>Carroll</b>                                              | 10c. City, Town or Location<br><b>Sykesville</b>                                                                                                                                                                                                                                            |                                                            | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                |                                              |
| 10e. Street and Number<br><b>4309 Morris Dr.</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | 10f. Zip Code<br><b>21784</b>                                                                                                                                                                                                                                                               |                                                            | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                |                                              |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>41-46</b>                                                                                                                              |                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                              |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+)                                                                                                                                                             |                                                            | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>                                                                  |                                              |
| 17. Father's Name (First, Middle, Last)<br><b>Clarence E. Hartley Sr.</b>                                                                                                                                                                                                                                                                                                                                                 |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marjorie Cave</b>                                                                                                                                                                                                                   |                                                            |                                                                                                                                                                                               |                                              |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>Wileen M. Hartley (Wife)</b>                                                                                                                                                                                                                                                                                                                                       |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4309 Morris Dr. Sykesville, Md. 21784</b>                                                                                                                                               |                                                            |                                                                                                                                                                                               |                                              |
| 20e. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>                                                                                                                                                                                       |                                                            | 20c. Location - City or Town, State<br><b>Smithsburg, Md.</b>                                                                                                                                 |                                              |
| 21. Signature of Funeral Service Licensee<br><i>Tennis L. Davis</i>                                                                                                                                                                                                                                                                                                                                                       |                                                                            | 22. Name and Address of Facility<br><b>Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783</b>                                                                                                                                                                                     |                                                            |                                                                                                                                                                                               |                                              |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                               |                                              |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                           |                                                                            | a. <b>INTRACEREBRAL HEMORRHAGE</b>                                                                                                                                                                                                                                                          |                                                            | 15 HOURS                                                                                                                                                                                      |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | Due to (or as a consequence of):                                                                                                                                                                                                                                                            |                                                            |                                                                                                                                                                                               |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | b. <b>HYPERTENSION</b>                                                                                                                                                                                                                                                                      |                                                            | 40 YEARS                                                                                                                                                                                      |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | Due to (or as a consequence of):                                                                                                                                                                                                                                                            |                                                            |                                                                                                                                                                                               |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | c.                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                               |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | Due to (or as a consequence of):                                                                                                                                                                                                                                                            |                                                            |                                                                                                                                                                                               |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | d.                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                               |                                              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                               |                                              |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                               |                                              |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                     |                                                            |                                                                                                                                                                                               |                                              |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                            |                                                                                                                                                                                               |                                              |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                             |                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                            |                                                            | 28d. Describe how injury occurred                                                                                                                                                             |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                  |                                              |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                            |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                               |                                              |
| 29b. Signature and title of certifier<br><i>John C. Abel MD</i>                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 29c. License number<br><b>13109</b>                                                                                                                                                                                                                                                         |                                                            | 29d. Date signed (Month, Day, Year)<br><b>June 30, 2000</b>                                                                                                                                   |                                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOHN C. ABEL</b>                                                                                                                                                                                                                                                                                                               |                                                                            | <b>4909 LOCKARD DRIVE OWINGS MILLS, MARYLAND 21117</b>                                                                                                                                                                                                                                      |                                                            |                                                                                                                                                                                               |                                              |
| 31. Date filed (Month, Day, Year)<br><b>JUL 3 2000</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 32. Registrar's Signature<br><i>B. Sparks</i>                                                                                                                                                                                                                                               |                                                            |                                                                                                                                                                                               |                                              |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22244

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

THERESA MILDRED HOFFBERGER

2. Date of Death

JUNE 29 2000

3. Time of Death

12:40 PM

4a. Facility Name (If not institution, give street and number)

BUCKINGHAM'S CHOICE

4b. City, Town, or Location of Death

ADAMSTOWN

4c. County of Death

FREDERICK

5. Social Security Number

015-18-5706

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 18, 1920

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Adamstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3200 Bakers Circle

10f. Zip Code

21710

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed/ Artist

16b. Kind of Business/Industry

Art

17. Father's Name (First, Middle, Last)

Arthur

18. Mother's Name (First, Middle, Maiden Surname)

Veronica

Fitzgerald

19a. Informant's Name/Relationship (Type, Print)

Lorraine Seth, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RR 2 Box 27, Harrisville, West Virginia 26362

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Smithsburg Crematory, June 30, 2000

Date

20c. Location - City or Town, State

Smithsburg, Maryland

21. Signature of Funeral Service Licensee

R. E. J. J.

M00255

22. Name and Address of Facility

Keeney and Basford P.A. Funeral Home

106 East Church Street, Frederick, Md. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

year

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerotic Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Casper E. Clingman

29c. License number

D16428

29d. Date signed (Month, Day, Year)

6/29/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CASPER CLINE 300 W. 9th ST FREDERICK MD 21701

31. Date filed (Month, Day, Year)

JUL 05 2000

32. Registrar's Signature

Benita B. Spauld

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22245

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1. Decedent's Name (First, Middle, Last)<br>Nellie Ann Hickmann                      |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  | 2. Date of Death<br>Month Day Year<br>July 2, 2000     |                                                                                      | 3. Time of Death<br>6:57 pm                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4a. Facility Name (If not institution, give street and number)<br>39498 Thomas Drive |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br>Mechanicsville |                                                                                      | 4c. County of Death<br>St. Mary's                       |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 5. Social Security Number<br>219-12-4062                                             |                                                                                                                                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br>77 Yrs.              |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>January 25, 1923 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 9. Birthplace (State or Foreign Country)<br>Maryland                                 |                                                                                                                                                       | 10a. State<br>MD                                                               |                                                                                                                                                                                                  | 10b. County<br>St. Mary's                              |                                                                                      | 10c. City, Town or Location<br>Mechanicsville           |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                      | 10e. Street and Number<br>39498 Thomas Drive                                                                                                          |                                                                                | 10f. Zip Code<br>20659                                                                                                                                                                           |                                                        | 10g. Citizen of What Country?<br>USA                                                 |                                                         |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                        | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |                                                         |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                |                                                                                | 16b. Kind of Business/Industry<br>Home                                                                                                                                                           |                                                        |                                                                                      |                                                         |  |
| 17. Father's Name (First, Middle, Last)<br>Thomas Bayard Hanson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |                                                                                                                                                       |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Elizabeth Saunders Hanson                                                                                                              |                                                        |                                                                                      |                                                         |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Herbert W. Hickmann/Husband                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |                                                                                                                                                       |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>39498 Thomas Dr. Mechanicsville, MD 20659                                                       |                                                        |                                                                                      |                                                         |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Joseph's Cemetery                                                       |                                                                                | 20c. Location - City or Town, State<br>7/8/00 Pomfret, Maryland                                                                                                                                  |                                                        |                                                                                      |                                                         |  |
| 21. Signature of Funeral Service Licensee<br>David C. Echols                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                      | 22. Name and Address of Facility<br>M00945 BRINSFIELD-ECHOLS FUNERAL HOME, P.A.<br>P.O. BOX 128 CHARLOTTE HALL, MD. 20622                             |                                                                                |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                         |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Leio myo sarcoma, metastatic<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |                                                                                      |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                         |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                      |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                         |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                      |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                         |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                      |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                         |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                      |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                         |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                    |                                                                                      |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                         |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                     |                                                                                      | 28a. Date of Injury (Month, Day, Year)                                                                                                                |                                                                                | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                        | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                         |  |
| 28d. Describe how Injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                |                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                        |                                                                                      |                                                         |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                           |                                                                                      |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                         |  |
| 29b. Signature and title of certifier<br>James Herring MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                      | 29c. License number<br>00052919                                                                                                                       |                                                                                | 29d. Date signed (Month, Day, Year)<br>7/3/00                                                                                                                                                    |                                                        |                                                                                      |                                                         |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>James Herring, MD 29795 Three Notch Rd. Charlotte Hall, MD 20622                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                      |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                         |  |
| 31. Date filed (Month, Day, Year)<br>JUL 05 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                      | 32. Registrar's Signature<br>B. Sparks                                                                                                                |                                                                                |                                                                                                                                                                                                  |                                                        |                                                                                      |                                                         |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22246

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                  |                                                                         |                                                                                      |                                                                  |                                                                                                  |  |                                                                                                                                                                                               |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Agnes Dale Hixson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                       |  | 2. Date of Death<br>Month Day Year<br>July 2 2000                                                                                                                                                |                                                                         |                                                                                      |                                                                  | 3. Time of Death<br>6:47 PM                                                                      |  |                                                                                                                                                                                               |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>Charles County Nursing Rehab Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                       |  | 4b. City, Town, or Location of Death<br>La Plata                                                                                                                                                 |                                                                         |                                                                                      |                                                                  | 4c. County of Death<br>Charles                                                                   |  |                                                                                                                                                                                               |
| Funeral<br>Director                           | 5. Social Security Number<br>440-03-1972                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                        |  | 7. Age (In yrs. last birthday)<br>83 Yrs.                                                                                                                                                        |                                                                         | 8. Date of Birth (Month, Day, Year)<br>May 11, 1917                                  |                                                                  | 9. Birthplace (State or Foreign Country)<br>Oklahoma                                             |  |                                                                                                                                                                                               |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                  |                                                                         |                                                                                      |                                                                  |                                                                                                  |  |                                                                                                                                                                                               |
| To Be Completed by Funeral Director           | 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10b. County<br>Charles                                                                                                                                                                                                                                                                                |  | 10c. City, Town or Location<br>Cobb Island                                                                                                                                                       |                                                                         |                                                                                      |                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |                                                                                                                                                                                               |
|                                               | 10e. Street and Number<br>12504 Neale Sound Drive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                       |  | 10f. Zip Code<br>20625                                                                                                                                                                           |                                                                         | 10g. Citizen of What Country?<br>USA                                                 |                                                                  |                                                                                                  |  |                                                                                                                                                                                               |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                               |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                 |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                         |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                  |  |                                                                                                                                                                                               |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) Teacher                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Teacher                                                                             |                                                                         |                                                                                      |                                                                  | 16b. Kind of Business/Industry<br>County Schools                                                 |  |                                                                                                                                                                                               |
|                                               | 17. Father's Name (First, Middle, Last)<br>Gilbert R. Dale                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bertha Harris Dale |                                                                                      |                                                                  |                                                                                                  |  |                                                                                                                                                                                               |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>J. Howard Hixson, III/Son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                       |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 193 Valley Lee, MD 20692-0193                                                          |                                                                         |                                                                                      |                                                                  |                                                                                                  |  |                                                                                                                                                                                               |
|                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Cemetery                                                                                                                                                                                                       |  | Date<br>7/6/00                                                                                                                                                                                   |                                                                         | 20c. Location - City or Town, State<br>Brentwood, Maryland                           |                                                                  |                                                                                                  |  |                                                                                                                                                                                               |
|                                               | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | M00945                                                                                                                                                                                                                                                                                                |  | 22. Name and Address of Facility<br>AREHART-ECHOLS FUNERAL HOME, P.A.<br>P.O. BOX 567 LA PLATA, MD. 20646                                                                                        |                                                                         |                                                                                      |                                                                  |                                                                                                  |  |                                                                                                                                                                                               |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Congestive Heart Failure-End Stage<br>Due to (or as a consequence of):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                  |                                                                         |                                                                                      |                                                                  |                                                                                                  |  | Approximate Interval Between Onset and Death                                                                                                                                                  |
|                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                  |                                                                         |                                                                                      |                                                                  |                                                                                                  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                  |                                                                         |                                                                                      |                                                                  |                                                                                                  |  |                                                                                                                                                                                               |
|                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                               |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                 |  | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                                         | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                |  |                                                                                                                                                                                               |
|                                               | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                       |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                                         |                                                                                      |                                                                  |                                                                                                  |  |                                                                                                                                                                                               |
|                                               | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                  |                                                                         |                                                                                      |                                                                  |                                                                                                  |  |                                                                                                                                                                                               |
|                                               | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                       |  | 29c. License number<br>D28352                                                                                                                                                                    |                                                                         | 29d. Date signed (Month, Day, Year)<br>July 3, 2000                                  |                                                                  |                                                                                                  |  |                                                                                                                                                                                               |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                  |                                                                         |                                                                                      |                                                                  |                                                                                                  |  |                                                                                                                                                                                               |
|                                               | 31. Date filed (Month, Day, Year)<br>JUL 05 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 32. Registrar's Signature<br>                                                                                                                                                                                     |  |                                                                                                                                                                                                  |                                                                         |                                                                                      |                                                                  |                                                                                                  |  |                                                                                                                                                                                               |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended # 4, P.G. GC, 7/5/00

State of Maryland / Department of Health and Mental Hygiene

00 22247

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                     |                                                                                                                                                                                                     |                                                                                                                                           |                                                                                                 |                                                                                                    |                                                                                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br>Raymond Leroy Johnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                     |                                                                                                                                                                                                     | 2. Date of Death<br>Month Day Year<br>June 27 2000                                                                                        |                                                                                                 | 3. Time of Death<br>2207                                                                           |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br>Doctor's Community Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                     |                                                                                                                                                                                                     | 4b. City, Town, or Location of Death<br>Lanham                                                                                            |                                                                                                 | 4c. County of Death<br>Prince George's                                                             |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br>213-38-3803                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br>59 Yrs.                                                                           | If Under 1 Year<br>Months Days                                                                                                                                                                      | If Under 24 Hrs.<br>Hours Min.                                                                                                            | 8. Date of Birth (Month, Day, Year)<br>July 22, 1940                                            |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Wash., D.C.                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                     |                                                                                                                                                                                                     |                                                                                                                                           |                                                                                                 |                                                                                                    |                                                                                                                                                                                                          |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                          | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. County<br>Prince George's                                                                                                                                                                                                                                                                          |                                                                                                                     | 10c. City, Town or Location<br>Bowie                                                                                                                                                                |                                                                                                                                           |                                                                                                 | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br>13205 - 9th Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                     | 10f. Zip Code<br>20715                                                                                                                                                                              |                                                                                                                                           | 10g. Citizen of What Country?<br>United States                                                  |                                                                                                    |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                           |                                                                                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                   |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Driver |                                                                                                                                                                                                     |                                                                                                                                           | 16b. Kind of Business/Industry<br>Private                                                       |                                                                                                    |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                              | 17. Father's Name (First, Middle, Last)<br>Raymond Johnson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                     |                                                                                                                                                                                                     | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Fletcher                                                                   |                                                                                                 |                                                                                                    |                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                | 19a. Informant's Name/Relationship (Type, Print)<br>Katie G. Johnson - Spouse                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                     |                                                                                                                                                                                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7924 Glenarden Parkway, Lanham, MD 20706 |                                                                                                 |                                                                                                    |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                              | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Cemetery                                                                                                                                                                                                          |                                                                                                                     | Data<br>7/3/2000                                                                                                                                                                                    |                                                                                                                                           | 20c. Location - City or Town, State<br>Brentwood, MD                                            |                                                                                                    |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br>John T. Stewart, III                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                     | 22. Name and Address of Facility<br>Stewart Funeral Home<br>4001 Benning Rd., N.E. Wash., D.C. 20019                                                                                                |                                                                                                                                           |                                                                                                 |                                                                                                    |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                              | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Respiratory Arrest secondary to pneumonia<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                     |                                                                                                                                                                                                     |                                                                                                                                           |                                                                                                 |                                                                                                    | Approximate Interval Between Onset and Death                                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Rib fracture                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                     |                                                                                                                                                                                                     |                                                                                                                                           |                                                                                                 |                                                                                                    | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                     |                                                                                                                                                                                                     |                                                                                                                                           |                                                                                                 |                                                                                                    |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                              | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                      |  | 28a. Date of Injury (Month, Day Year)<br>May 29 2000                                                                                                                                                                                                                                                    |                                                                                                                     | 28b. Time of Injury<br>1708 M                                                                                                                                                                       |                                                                                                                                           | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                    | 28d. Describe how injury occurred<br>Victim front seat passenger struck by another vehicle                                                                                                               |  |
|                                                                                                                                                                                                                                                                                                                                              | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                       |  | 29b. Signature and title of certifier<br>Salvador S. Foster, DO                                                                                                                                                                                                                                         |                                                                                                                     | 29c. License number<br>H0055927                                                                                                                                                                     |                                                                                                                                           | 29d. Date signed (Month, Day, Year)<br>June 29, 2000                                            |                                                                                                    |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                              | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Salvador S. Foster, 3001 Hospital Drive, Cheverly, Maryland 20785                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |                                                                                                                     |                                                                                                                                                                                                     |                                                                                                                                           |                                                                                                 |                                                                                                    |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                              | 31. Date filed (Month, Day, Year)<br>JUN 30 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 32. Registrar's Signature<br>[Signature]                                                                                                                                                                                                                                                                |                                                                                                                     |                                                                                                                                                                                                     |                                                                                                                                           |                                                                                                 |                                                                                                    |                                                                                                                                                                                                          |  |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22248

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Shirley Ann Jones

2. Date of Death

June 25, 2000

3. Time of Death

8:50 P.M.

4a. Facility Name (If not institution, give street and number)

Regency Nursing Center

4b. City, Town, or Location of Death

Forestville

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

220-38-2950

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-22-1942

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Forestville

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

2414 Boones Lane

10f. Zip Code

20747

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Microfiche Clerk

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

James Moore

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Folk

19a. Informant's Name/Relationship (Type, Print)

Leonard Andrew Jones / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2414 Boones Lane Forestville, Maryland 20747

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Crematory

Date

6-29-00

20c. Location - City or Town, State

Brentwood

21. Signature of Funeral Service Licensee

M 1015

22. Name and Address of Facility

Fort Lincoln Funeral Home  
3401 Bladensburg Road Brentwood, Maryland 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Ovarian Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George C. Hajjar, Jr.

29c. License number

D39550

29d. Date signed (Month, Day, Year)

June 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. #D Lanham, MD 20706

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

B. Hajjar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

2

Jan 2 5 000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 22249

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bobby Jones

2. Date of Death

Month June Day 26 Year 2000

3. Time of Death

8:45PM

4a. Facility Name (If not institution, give street and number)

Fort Washington Hospital

4b. City, Town, or Location of Death

Fort Washington

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

440-28-3213

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

69

8. Date of Birth

Month May Day 25 Year 1931

9. Birthplace (State or Foreign Country)

Tulsa, OK.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Forest Heights

10d. Inside City Limits

Y Yes 2 No

10e. Street and Number

151 Onondaga Drive

10f. Zip Code

20745

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2X Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No Retired  
If Yes, Give Year or Dates: 1971

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1X Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

US Air Force

16b. Kind of Business/Industry

Military

17. Father's Name (First, Middle, Last)

Willis Jones

18. Mother's Name (First, Middle, Maiden Summa)

Leulah Kidd

19a. Informant's Name/Relationship (Type, Print)

Denise G. Jones/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as item 10

20a. Method of Disposition

1X Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington Nat. Cemetery 7/5/2000 Arlington, VA.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

George P. Kalas Funeral Home, P.A.  
6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

1. Congestive Cardiac Failure

Due to (or as a consequence of):

Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Diabetes Mellitus - I

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1. Dementia.  
2. Chronic Renal Failure  
3. Peripheral Vascular Disease

23b. Did tobacco use contribute to the cause of death?

1 Yes 2X No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2X No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2X No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home

5 Residence

8 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation  
2 Accident 6 Could not be determined  
3 Suicide  
4 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]* R. C. [unclear]

29c. License number

D 0051913

29d. Date signed (Month, Day, Year)

06/27/2000

30. Name and address of person who completed cause of death (Item 23) (Type, Print)

BET JENKI-S. CHARY MD, 6196 Oxon Hill Road Suite 520, Oxon Hill, MD-20745

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22250

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GRACE J. JONES

2. Date of Death  
Month Day Year  
June 25 20003. Time of Death  
2:45pmFuneral  
Director

4a. Facility Name (If not institution, give street and number)

WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

5. Social Security Number

578 26 8704

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
8/6/1919

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7620 Maple Avenue

10f. Zip Code

20912

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House Keeper

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

Frank Justice

18. Mother's Name (First, Middle, Maiden Summa)

Fannie Jenkins

19a. Informant's Name/Relationship (Type, Print)

Jocile A. Fowler, Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1377 Downing St. N.E., Wash. D.C. 20018

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park 6/29/00 Landover, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ruth C. Hall

878

22. Name and Address of Facility

HALL BROTHERS FUNERAL HOME

20001

621 Florida Ave., NW, Washington, DC.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Gastroesophageal reflux

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End stage renal disease

Hypertensive heart disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Norton Elson

29c. License number

D20362

29d. Date signed (Month, Day, Year)

June 25, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Norton Elson

6525 Belcrest Rd Hyattsville MD 20782

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

B. Jones

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

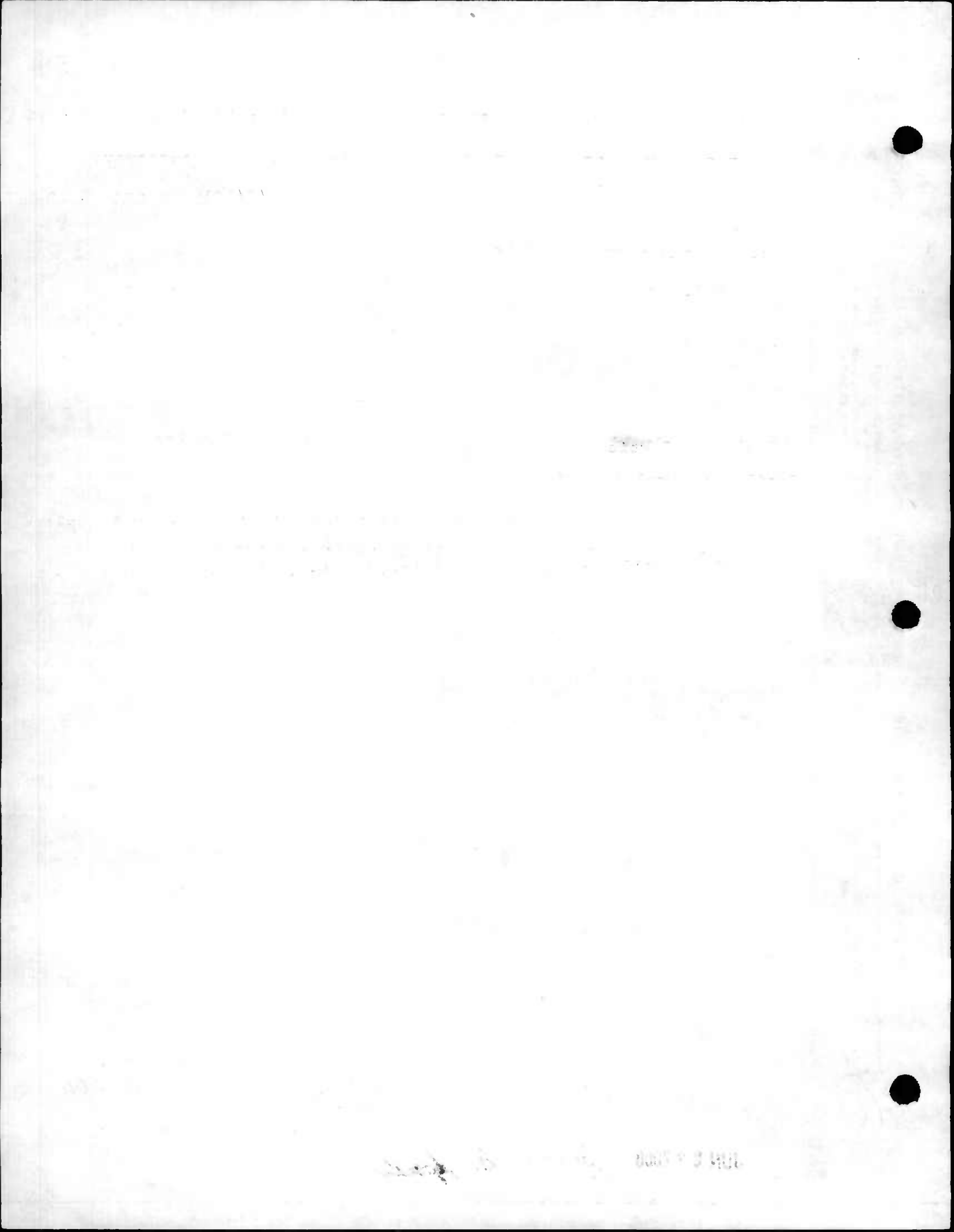
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Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22251

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                              |                                                           |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br><b>Lawrence Edward Jolliffe</b>                  |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>JUNE 25 2000</b> |                                                                                                                                                                                                  | 3. Time of Death<br><b>14:28 PM</b>                                                            |                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4e. Facility Name (If not institution, give street and number)<br><b>3818 IRONWOOD PLACE</b> |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>LANDOVER</b>   |                                                                                                                                                                                                  | 4c. County of Death<br><b>PRINCE GEORGE'S</b>                                                  |                                                                                                                                                    |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5. Social Security Number<br><b>164-34-3811</b>                                              | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>57</b> Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                            | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 12, 1943</b>                                                                                                                                      |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Usual Residence of Decedent                                                                  |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                              |                                                           |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                    |
| 10a. State<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              | 10b. County<br><b>Prince Georges</b>                                                                                                                                                                                                                                                                     |                                                  | 10c. City, Town or Location<br><b>Lanham</b>                                                                                                                                                 |                                                           |                                                                                                                                                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                    |
| 10e. Street and Number<br><b>7323 Green Oak Terrace</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                  | 10f. Zip Code<br><b>20706</b>                                                                                                                                                                |                                                           | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                      |                                                                                                |                                                                                                                                                    |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1965-</b><br>If Yes, Give Year or Dates: <b>1969</b>                                                                                                                               |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                           |                                                                                                                                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                                                                                                                    |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mechanic</b>                                                                 |                                                           |                                                                                                                                                                                                  | 16b. Kind of Business/Industry<br><b>Self employed</b>                                         |                                                                                                                                                    |
| 17. Father's Name (First, Middle, Last)<br><b>F. Dale Jolliffe</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Catherine H. Pensenstad</b>                                                                                                          |                                                           |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                    |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Christine Jolliffe Wife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7323 Green Oak Terrace, Lanham, Md. 20706</b>                                            |                                                           |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                    |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                                                                                      |                                                           | 20c. Location - City or Town, State<br><b>Alexandria, VA.</b>                                                                                                                                    |                                                                                                |                                                                                                                                                    |
| 21. Signature of Funeral Service Licensee<br><b>Robert G. Beall M00025</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                  | 22. Name and Address of Facility<br><b>Beall Funeral Home<br/>6512 N.W. Crain Hwy., Bowie, Md. 20715</b>                                                                                     |                                                           |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                    |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) <b>MULTIPLE INJURIES</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                              |                                                           |                                                                                                                                                                                                  |                                                                                                | Approximate Interval Between Onset and Death                                                                                                       |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                              |                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                                                                |                                                                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                              |                                                           | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                            |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |                                                  |                                                                                                                                                                                              |                                                           |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                    |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              | 28a. Date of Injury (Month, Day, Year)<br><b>6/25/00</b>                                                                                                                                                                                                                                                 |                                                  | 28b. Time of Injury<br><b>1:40</b> P M                                                                                                                                                       |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |                                                                                                | 28d. Describe how injury occurred subject caught in explosion                                                                                      |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>building</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>3818 Ironwood Place, P.G. County, MD</b>                                                                  |                                                           |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                    |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                               |                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                              |                                                           |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                    |
| 29b. Signature and title of certifier<br><b>Stephen S. Radentz</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                  | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                       |                                                           | 29d. Date signed (Month, Day, Year)<br><b>JUNE 26, 2000</b>                                                                                                                                      |                                                                                                |                                                                                                                                                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                              |                                                           |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                    |
| 31. Date filed (Month, Day, Year)<br><b>JUL 05 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              | 32. Registrar's Signature<br><b>Benjamin A. Sparks</b>                                                                                                                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                           |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                                    |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22252

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PRESTON S JONES

2. Date of Death

Month Day Year  
July 4, 2000

3. Time of Death

1300hrs

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Hartley Hall Nursing Home

4b. City, Town, or Location of Death

Pocomoke City

4c. County of Death

Worcester

5. Social Security Number

215-26-4614

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

92

if Under 1 Year

Months Days

if Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
2/14/1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Worcester

10c. City, Town or Location

Pocomoke City

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1006 Market Street

10f. Zip Code

21851

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Waterman

16b. Kind of Business/Industry

Seafood

17. Father's Name (First, Middle, Last)

Chestnut Jones

18. Mother's Name (First, Middle, Maiden Surname)

Winnie Smack

19a. Informant's Name/Relationship (Type, Print)

Milton Payne/ Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 311, Fruitland, MD 21826

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☒ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Portersville Cem.

Date

7/6/00

20c. Location - City or Town, State

Stockton, MD 21864

21. Signature of Funeral Service Licensee

Michael A. Dean MD1129

22. Name and Address of Facility

Holloway Melson Funeral Home, P.A.

103 Linden Ave., Pocomoke City, MD 21851

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Diabetic Renal Disease 8 yrs

Due to (or as a consequence of):

b. Insulin Dependent Diabetes Mellitus 8 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerotic Heart Disease.

Coronary Artery Disease. Essential

Hypertension. Senile Dementia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accidental ☐ Could not be determined  
☐ Suicidal ☐ Homicidal28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gregorio M. Belloso M.D.

29c. License number

D 29505

29d. Date signed (Month, Day, Year)

7-4-2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, MD; 5302 CHINABERRY DR., SALISBURY, MD 21801

31. Date filed (Month, Day, Year)

JUL 05 2000

32. Registrar's Signature

James B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22253

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |  |
|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>HERBERT G. KADOW</b>                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                               |  | 2. Date of Death<br>Month Day Year<br><b>JUNE 25, 2000</b>                                                                                                                                                                                                                                                                                                                                                                       |  | 3. Time of Death<br><b>1:40 AM</b>                                                                                                                                                                                                                                                                      |  |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>NATIONAL LUTHERAN HOME</b>                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                               |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>                                                                                                                                                                                                                                                                                                                                                                         |  | 4c. County of Death<br><b>MONTGOMERY CO.</b>                                                                                                                                                                                                                                                            |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>134-07-3202</b>                                                                                                                                                                                                                                          |  | 6. Sex<br><b>MM</b> 2 <input type="checkbox"/> F                                                                                                                                                                                                                              |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.                                                                                                                                                                                                                                                                                                                                                                                 |  | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 12, 1912</b>                                                                                                                                                                                                                                             |  |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>NEW YORK</b>                                                                                                                                                                                                                              |  | 10a. State<br><b>MD.</b>                                                                                                                                                                                                                                                      |  | 10b. County<br><b>MONTGOMERY</b>                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10c. City, Town or Location<br><b>ROCKVILLE</b>                                                                                                                                                                                                                                                         |  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                         |  | 10e. Street and Number<br><b>9701- VEIRS DRIVE</b>                                                                                                                                                                                                                            |  | 10f. Zip Code<br><b>20850</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                                             |  |  |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates<br><b>UNKNOWN</b>                                                                                                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                 |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                                                                                                 |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collage (1-4 or 5+)<br><b>2 YRS.</b>                                                                                                                                                      |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BANKER</b>                                                                                                                                                    |  | 16b. Kind of Business/Industry<br><b>BANKING</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 17. Father's Name (First, Middle, Last)<br><b>HENRY KADOW</b>                                                                                                                                                                                                                                           |  |  |
|                                               | 17. Mother's Name (First, Middle, Maiden Surname)<br><b>ALVINA RINOW</b>                                                                                                                                                                                                                 |  | 18. Informant's Name/Relationship (Type, Print)<br><b>MRS. JANET HONECKER-DAUGHTER-</b>                                                                                                                                                                                       |  | 19a. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8344-WAGON WHEEL RD., ALEXANDRIA, VA. 22309</b>                                                                                                                                                                                                                                                                              |  | 19b. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                         |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY-6/26-ALEXANDRIA, VA.</b>                                                                                                                                                             |  | 20b. Date<br><b>6/26</b>                                                                                                                                                                                                                                                      |  | 20c. Location - City or Town, State<br><b>VA.</b>                                                                                                                                                                                                                                                                                                                                                                                |  | 21. Signature of Funeral Home Licensee<br><b>W. H. Hysong</b>                                                                                                                                                                                                                                           |  |  |
|                                               | 22. Name and Address of Facility<br><b>Hysong Co., Inc.<br/>6510- 16th St., NW, Wash., DC</b>                                                                                                                                                                                            |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>pneumonia</b><br><b>Chronic obstructive pulmonary disease</b> |  | Approximate Interval Between Onset and Death<br><b>5 days</b><br><b>years</b>                                                                                                                                                                                                                                                                                                                                                    |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                |  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |
|                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicidal 4 <input type="checkbox"/> Homicidal<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)<br><b>June 25, 2000</b>                                                                                                                                                                                                                |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                         |  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred                                                                                                                                                                                                                                                        |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Charles W. Karesh MD</b>                                                                                                                                                                                                                                    |  |  |
|                                               | 29c. License number<br><b>D21726</b>                                                                                                                                                                                                                                                     |  | 29d. Date signed (Month, Day, Year)<br><b>June 25, 2000</b>                                                                                                                                                                                                                   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Charles W. Karesh- 9701- Veirs Dr., Rockville, Md.</b>                                                                                                                                                                                                                                                                            |  | 31. Data filed (Month, Day, Year)<br><b>JUN 27 2000</b>                                                                                                                                                                                                                                                 |  |  |
| 32. Registrar's Signature<br><b>B. Smith</b>  |                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



10/10/01

10/10/01

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22254

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Norma Beatrice Kelso

2. Date of Death

Month

Day

Year

3. Time of Death

JUNE 22 2000 2:55PM

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

304-26-1522

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sept. 25, 1925

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

200 S. Southwood Avenue

10f. Zip Code

21401

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own home

17. Father's Name (First, Middle, Last)

Vernie Sarles

18. Mother's Name (First, Middle, Maiden Surname)

Kate Ferguson

19a. Informant's Name/Relationship (Type, Print)

Robert Kelso husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

200 S. Southwood Ave., Annapolis, Md. 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Md. Veterans Cemetery

20c. Location - City or Town, State

Crownsville, Md.

21. Signature of Funeral Service Licensee

Robert G. Beall

M00025

22. Name and Address of Facility

Beall Funeral Home

6512 N.W. Crain Hwy., Bowie, Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis  
Due to (or as a consequence of):b. Multiple Transient Ischemic attacks  
Due to (or as a consequence of):c. Congestive heart failure  
Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Marcelle M. M.

29c. License number

D050514

29d. Date signed (Month, Day, Year)

6/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mehru Hasha Suel, Mrs. 6510 Leniworth ave. Suit 210, Riverdale

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

B. Spauld

20737

5

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22255

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  |
|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Charlotte Knox                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  | 2. Date of Death<br>Month Day Year<br>June 23, 2000                                                                                                                                              |  |                                                                                      |                                                                  | 3. Time of Death<br>1805                                                                           |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>PENINSULA REGIONAL MEDICAL CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                         |  | 4b. City, Town, or Location of Death<br>SALISBURY                                                                                                                                                |  |                                                                                      |                                                                  | 4c. County of Death<br>WICOMICO                                                                    |  |
| Funeral<br>Director                           | 5. Social Security Number<br>215-88-2447                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 7. Age (In yrs. last birthday)<br>71 Yrs.                                                                                                                                                        |  | 8. Date of Birth (Month, Day, Year)<br>JAN 25, 1929                                  |                                                                  | 9. Birthplace (State or Foreign Country)<br>MD                                                     |  |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Funeral Director           | 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. County<br>TALBOT                                                                                                                                                                                                                                                                                   |  | 10c. City, Town or Location<br>WITTMAN                                                                                                                                                           |  |                                                                                      |                                                                  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                               | 10e. Street and Number<br>8796 CUMMINGS ROAD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  | 10f. Zip Code<br>21676                                                                                                                                                                           |  | 10g. Citizen of What Country?<br>USA                                                 |                                                                  |                                                                                                    |  |
|                                               | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |                                                                                                    |  |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 2<br>College (1-4or 5+) 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER                                                                           |  |                                                                                      | 16b. Kind of Business/Industry<br>OWN HOME                       |                                                                                                    |  |
|                                               | 17. Father's Name (First, Middle, Last)<br>LLOYD KNOX                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>LOUISE BRANDOW                                                                                                                              |  |                                                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>DOROTHY JEAN CHEEZUM/SISTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8791 CUMMINGS RD WITTMAN, MD 21676                                                              |  |                                                                                      |                                                                  |                                                                                                    |  |
|                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>OLIVET CEMETERY                                                                                                                                                                                                               |  | Data<br>6-27-00                                                                                                                                                                                  |  | 20c. Location - City or Town, State<br>ST. MICHAELS, MD                              |                                                                  |                                                                                                    |  |
|                                               | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br>FELLOWS, HELFENBEIN & NEWMAN FUNERAL HOME PA<br>200 S. HARRISON ST. EASTON, MD 21601                                                                         |  |                                                                                      |                                                                  |                                                                                                    |  |
|                                               | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Metastatic breast cancer<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  |
|                                               | 23b. Part II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Mental retardation                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  |
|                                               | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                      |  |                                                                                      |                                                                  |                                                                                                    |  |
|                                               | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  |
|                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                             |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |  | 28b. Time of Injury<br>M                                                                                                                                                                         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                  |  |
|                                               | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  |
| State Registrar                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  | 29b. Signature and title of certifier<br>                                                                     |  | 29c. License number<br>J 25674                                                       |                                                                  | 29d. Date signed (Month, Day, Year)<br>6/26/00                                                     |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>J. A. Cockey, M.D. 100 Power Street Salisbury, MD 21804                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  |
|                                               | 31. Date filed (Month, Day, Year)<br>JUN 27 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 32. Registrar's Signature<br>                                                                                                                                                                                       |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                    |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22256

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|                                                                                                 |                                                                            |                                                           |                                                            |                                                             |
|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>JOHN FRANCIS KNIPPLE</b>                         |                                                                            | 2. Date of Death<br>Month Day Year<br><b>June 26 2000</b> |                                                            | 3. Time of Death<br><b>1:58 A.M.</b>                        |
| 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Hospital</b> |                                                                            | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |                                                            | 4c. County of Death                                         |
| 5. Social Security Number<br><b>219-34-5744</b>                                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.          | 8. Date of Birth (Month, Day, Year)<br><b>Jun 27, 1938</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |

|                                                                                                                                                                                                                                       |                                 |                                                                                                                                                   |  |                                                                                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Usual Residence of Decedent                                                                                                                                                                                                           |                                 |                                                                                                                                                   |  |                                                                                                                                                                                              |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                         | 10b. County<br><b>Frederick</b> | 10c. City, Town or Location<br><b>Frederick</b>                                                                                                   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                               |
| 10e. Street and Number<br><b>7744 Kemp Lane</b>                                                                                                                                                                                       |                                 | 10f. Zip Code<br><b>21702</b>                                                                                                                     |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                               |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                        |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                               |                                 | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)                       |  |                                                                                                                                                                                              |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Assitant Chief Dispatcher</b>                                                                                         |                                 | 16b. Kind of Business/Industry<br><b>Emergency Communications</b>                                                                                 |  |                                                                                                                                                                                              |
| 17. Father's Name (First, Middle, Last)<br><b>John Eli Knipple</b>                                                                                                                                                                    |                                 | 18. Mother's Name (First, Middle, Maiden Sumama)<br><b>Magdalene Lillian Gilbert</b>                                                              |  |                                                                                                                                                                                              |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Katherine Knipple/Wife</b>                                                                                                                                                     |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7744 Kemp Lane, Frederick, Maryland 21702</b> |  |                                                                                                                                                                                              |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt Olivet Cemetery Jun 29, 2000</b>                                  |  | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>                                                                                                                            |
| 21. Signature of Funeral Service Licensee<br><b>Keith L. Roberson</b> M00706                                                                                                                                                          |                                 | 22. Name and Address of Facility<br><b>Keeney &amp; Basford P.A. Funeral Home<br/>106 East Church St, Frederick, Maryland 21701</b>               |  |                                                                                                                                                                                              |

|                                                                                                                                                                                                                                                                                                                    |  |                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------|
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>ISCHEMIC CARDIOMYOPATHY</b> |  | Approximate Interval Between Onset and Death<br><b>15 YEARS</b> |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                   |  |                                                                 |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                   |  |                                                                 |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                   |  |                                                                 |

|                                                                                                                        |  |                                                                                                                                                                                                  |                                                                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                                                                                                    |
|                                                                                                                        |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |

|                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                          |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       | 28b. Time of Injury<br><b>M</b>   |
|                                                                                                                                                                                                                                                                            |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                 | 28d. Describe how injury occurred |
|                                                                                                                                                                                                                                                                            |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                   |

|                                                                                                                                                                                                                                                                                                                                                                                                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                              |                                       |                                                             |
|--------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------|
| 29b. Signature and title of certifier<br><b>Miss Rose MD</b> | 29c. License number<br><b>RES-000</b> | 29d. Date signed (Month, Day, Year)<br><b>JUNE 26, 2000</b> |
|--------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------|

|                                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICOL ROTHMAN JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205</b> |
|---------------------------------------------------------------------------------------------------------------------------------------------------------|

|                                                         |                                                 |
|---------------------------------------------------------|-------------------------------------------------|
| 31. Date filed (Month, Day, Year)<br><b>JUN 28 2000</b> | 32. Registrar's Signature<br><b>[Signature]</b> |
|---------------------------------------------------------|-------------------------------------------------|

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



1000 1000 1000

1000 1000 1000

1000 1000 1000  
1000 1000 1000  
1000 1000 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22257

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUTH BEDDOW KACHEL

2. Date of Death

Month Day Year  
JULY 1, 2000

3. Time of Death

1440

4a. Facility Name (If not institution, give street and number)

33 BATTERSEA CT.

4b. City, Town, or Location of Death

OCEAN PINES

4c. County of Death

WORCESTER

Funeral  
Director

5. Social Security Number

142-30-5683

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
6-30-11

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

MD

10b. County

WORCESTER

10c. City, Town or Location

OCEAN PINES

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

33 BATTERSEA CT.

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

GUIDANCE COUNSELOR

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

JOHN E. BEDDOW

18. Mother's Name (First, Middle, Maiden Surname)

PEARL SOBEY

19a. Informant's Name/Relationship (Type, Print)

JOHN KACHEL

SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

33 BATTERSEA CT. OCEAN PINES, MD., 21811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ODD FELLOWS CEMETERY 7-3

Date

20c. Location - City or Town, State

FRACKVILLE, PA.

21. Signature of Funeral Service Licensee

John A. Ullrich

22. Name and Address of Facility

ULLRICH FUNERAL HOME BERLIN, MD., 21811

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Urosepsis

Due to (or as a consequence of):

b. Renal Failure

Due to (or as a consequence of):

c. Myocardial Infarction

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Signature and title of certifier

John A. Ullrich

29d. License number

H0053775

29e. Date signed (Month, Day, Year)

07/02/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11107 RAE TRAIL RD Berlin MD 21811

FAITH JABERS, D.O.

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 5 2000

32. Registrar's Signature

John A. Ullrich

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7000.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22258  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Eleanor P. Lewis

2. Date of Death

Month Day Year  
June 27 2000

3. Time of Death

9:45AM

4a. Facility Name (If not institution, give street and number)

6040 Sargent Rd., #4102

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-18-7129

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar. 31, 1916

9. Birthplace (State or Foreign Country)

Wash., D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6040 Sargent Rd., #4102

10f. Zip Code

20782

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
African  
American15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Executive Assistant

16b. Kind of Business/Industry

Government - IRS

17. Father's Name (First, Middle, Last)

Charles Washington

18. Mother's Name (First, Middle, Maiden Surname)

Mary Neal

19a. Informant's Name/Relationship (Type, Print)

Eduardo Potillo - Grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4378 Dubois Pl., S.E. Wash., D.C. 20019

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lincoln Memorial Cem.

Date

7/1/2000

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

John T. Stewart, III

22. Name and Address of Facility

Stewart Funeral Home

4001 Benning Rd., N.E. Wash., D.C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Stroke

Due to (or as a consequence of):

b. Atherosclerosis

Due to (or as a consequence of):

c. Hypertensive Cardiovascular disease

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician2 ☐ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Patricia Davidson

29c. License number

D0032487

29d. Date signed (Month, Day, Year)

June 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Patricia Davidson - 106 Irving St., N.W.; #118, Wash., D.C. 200010-2975

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

Patricia Davidson

Baltimore, Maryland 21215-0020

perma. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23b show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22259

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                               |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                |                                                                                                |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>WILLIAM GARFIELD LYTLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                               | 2. Date of Death<br>Month Day Year<br>JUNE 22, 2000                                                                                                                                              |                                                                                      |                                                       |                                                | 3. Time of Death<br>10:30pm                                                                    |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>PRINCE GEORGES COUNTY HOSPITAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                               | 4b. City, Town, or Location of Death<br>CHEVERLY                                                                                                                                                 |                                                                                      |                                                       |                                                | 4c. County of Death<br>PRINCE GEORGES                                                          |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>578-66-2902                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                          |                               | 7. Age (In yrs. last birthday)<br>51 Yrs.                                                                                                                                                        |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>APRIL 23, 1949 |                                                | 9. Birthplace (State or Foreign Country)<br>WASHINGTON DC                                      |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                               |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                |                                                                                                |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 10b. County<br>PRINCE GEORGES                                                                                                                       |                               | 10c. City, Town or Location<br>BOWIE                                                                                                                                                             |                                                                                      |                                                       |                                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br>1213 PARKINGTON LANE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                               | 10f. Zip Code<br>20716                                                                                                                                                                           |                                                                                      | 10g. Citizen of What Country?<br>UNITED STATES        |                                                |                                                                                                |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                      |                                                       |                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK                               |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>ROUTE SUPERVISOR                                                                    |                                                                                      |                                                       |                                                | 16b. Kind of Business/Industry<br>PRIVATE                                                      |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>WILLIAM G. LYTLE SR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARGARET MORGAN                                                                                                                             |                                                                                      |                                                       |                                                |                                                                                                |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 19a. Informant's Name/Relationship (Type, Print)<br>WILLIE ANN LYTLE/SISTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5014 ADDISON RD, CAPITOL HEIGHTS, MD 20743                                                      |                                                                                      |                                                       |                                                |                                                                                                |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MARYLAND NATIONAL CEMETERY 6-29-00 LAUREL, MD                             |                               |                                                                                                                                                                                                  |                                                                                      | 20c. Location - City or Town, State                   |                                                |                                                                                                |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>Ketter, Anne M1085                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                               | 22. Name and Address of Facility<br>ALEXANDER S. POPE FUNERAL HOME<br>5538 MARLBORO PIKE, FORESTVILLE, MD 20747                                                                                  |                                                                                      |                                                       |                                                |                                                                                                |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>CARCINOMA LUNG</u><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                               |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                |                                                                                                |                                                                                                           | Approximate Interval Between Onset and Death                                                                                                                                                             |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                               |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                |                                                                                                |                                                                                                           | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                               |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                |                                                                                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                                                                                                                          | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                     |                               |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                |                                                                                                |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                                     | 28b. Time of Injury<br>M      |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                       | 28d. Describe how injury occurred              |                                                                                                |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                                                                                     |                               |                                                                                                                                                                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                                       |                                                |                                                                                                |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                               |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                |                                                                                                |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
| 29b. Signature and title of certifier<br>Neil H. Meade M.D.                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     | 29c. License number<br>D14220 |                                                                                                                                                                                                  |                                                                                      |                                                       | 29d. Date signed (Month, Day, Year)<br>6-26-00 |                                                                                                |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Neil H. Meade 9811 Millard Dr Laurel MD 20708                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                     |                               |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                |                                                                                                |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |
| 31. Date filed (Month, Day, Year)<br>JUN 29 2000                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 32. Registrar's Signature<br>[Signature]                                                                                                                                                                                                                                                                |                                                                                                                                                     |                               |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                |                                                                                                |                                                                                                           |                                                                                                                                                                                                          |                                                                                                                                             |  |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22260

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas Frank Lusby II, M.D.

2. Date of Death

June 29 2000 Year

3. Time of Death

1205 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

6200 Sandy Point Road

4b. City, Town, or Location of Death

Prince Frederick Calvert

4c. County of Death

Calvert

5. Social Security Number

220 44 2280

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb 17 1917 Year

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Calvert

10c. City, Town or Location

Prince Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6200 Sandy Point Road

10f. Zip Code

20678

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

8+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Medical doctor

16b. Kind of Business/Industry

Health care

17. Father's Name (First, Middle, Last)

Maurice T. Lusby, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Bowen

19a. Informant's Name/Relationship (Type, Print)

Thomas F. Lusby III, D.D.S. 6190 Sandy Pt. Rd. Prince Frederick MD 20678

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Thomas F. Lusby III, D.D.S. 6190 Sandy Pt. Rd. Prince Frederick MD 20678

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Pauls Episcopal Cemetery

Date: July 3, 2000

20c. Location - City or Town, State

Prince Frederick Maryland

21. Signature of Funeral Service licensee

Brousch

22. Name and Address of Facility

Rausch Funeral Home PA

4405 Broome Is. Rd. Port Republic MD 20676

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

b. ATHEROSCLEROTIC HEART DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Few minutes

Few years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① Recent Left cerebrovascular accident (6/7/2000)

② Chronic Bronchial Asthma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

ATMUNSHI M.D. Attending Physician

29c. License number

D 19427

29d. Date signed (Month, Day, Year)

6/30/00

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

ANWAR MUNSHI M.D. SHE 303 110 Hosp Road, Prince Frederick MD 20678

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



CANDELARIO MARTINEZ-RAMOS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22261

amend item 23a,27,28a.b.c.d.e.f per me G785 7/14/00

Certificate of Death

Reg. No.

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                                                   |                                                           |                                                                                             |                                                                                                |                                                                                                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1. Decedent's Name (First, Middle, Last)<br><b>CANDELARIO MARTINEZ-RAMOS</b>                   |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                                                   | 2. Date of Death<br>Month Day Year<br><b>JUNE 28 2000</b> |                                                                                             | 3. Time of Death<br><b>18:19 PM</b>                                                            |                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4a. Facility Name (If not institution, give street and number)<br><b>11903 CENTERHILL ROAD</b> |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                                                   | 4b. City, Town, or Location of Death<br><b>WHEATON</b>    |                                                                                             | 4c. County of Death<br><b>MONTGOMERY</b>                                                       |                                                                                                                                                                                                             |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 5. Social Security Number<br><b>Unknown</b>                                                    | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>34 Yrs.</b> | If Under 1 Year<br>Months Days                                                                                                                                                                                    | If Under 24 Hrs.<br>Hours Min.                            | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 2, 1966</b>                                  |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>El Salvador</b>                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Usual Residence of Decedent                                                                    |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                                                   |                                                           |                                                                                             |                                                                                                |                                                                                                                                                                                                             |
| 10a. State<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                | 10b. County<br><b>Montgomery</b>                                                                                                                                                                                                                                                                         |                                                  | 10c. City, Town or Location<br><b>Wheaton</b>                                                                                                                                                                     |                                                           |                                                                                             | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                             |
| 10e. Street and Number<br><b>11903 Center Hill Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |                                                                                                                                                                                                                                                                                                          |                                                  | 10f. Zip Code<br><b>20902</b>                                                                                                                                                                                     |                                                           | 10g. Citizen of What Country?<br><b>El Salvador</b>                                         |                                                                                                |                                                                                                                                                                                                             |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                        |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Specify: <b>El Salvadoran</b> |                                                           |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Hispanic</b>                     |                                                                                                                                                                                                             |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3rd</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                                                                                                                          |                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Landscaper</b>                                                                                    |                                                           |                                                                                             | 16b. Kind of Business/Industry<br><b>Lawn Care</b>                                             |                                                                                                                                                                                                             |
| 17. Father's Name (First, Middle, Last)<br><b>Felis Martinez</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                |                                                                                                                                                                                                                                                                                                          |                                                  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Gregoria Ramos</b>                                                                                                                                          |                                                           |                                                                                             |                                                                                                |                                                                                                                                                                                                             |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Cristina Mendoza Martinez</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                |                                                                                                                                                                                                                                                                                                          |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11903 Center Hill St., Wheaton, Md. 20902</b>                                                                 |                                                           |                                                                                             |                                                                                                |                                                                                                                                                                                                             |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Family Cemetery</b>                                                                                                                                                                                                         |                                                  | Data<br><b>07-10-00</b>                                                                                                                                                                                           |                                                           | 20c. Location - City or Town, State<br><b>Sangerdo, El Salvador</b>                         |                                                                                                |                                                                                                                                                                                                             |
| 21. Signature of Funeral Service Licensee<br><b>Wanda C. Bacon CC0361</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |                                                                                                                                                                                                                                                                                                          |                                                  | 22. Name and Address of Facility<br><b>BACON FUNERAL HOME, INC. 3447 14th St., N.W. Washington, D. C. 20010</b>                                                                                                   |                                                           |                                                                                             |                                                                                                |                                                                                                                                                                                                             |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ISOPROPANOL INTOXICATION</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                                                   |                                                           |                                                                                             |                                                                                                | Approximate Interval Between Onset and Death                                                                                                                                                                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                                                   |                                                           |                                                                                             |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                                                   |                                                           |                                                                                             |                                                                                                | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                                                   |                                                           |                                                                                             |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                          |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |                                                  |                                                                                                                                                                                                                   |                                                           |                                                                                             |                                                                                                |                                                                                                                                                                                                             |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                | 28a. Date of Injury (Month, Day, Year)<br><b>found 6/28/2000</b>                                                                                                                                                                                                                                         |                                                  | 28b. Time of Injury<br><b>found 5:00 M</b>                                                                                                                                                                        |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred<br><b>unknown</b>                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Residence</b>                                                                                                                                                                                               |                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>11903 Centerhill Rd., Wheaton, Md.</b>                                                                                         |                                                           |                                                                                             |                                                                                                |                                                                                                                                                                                                             |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                        |                                                                                                |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                                                   |                                                           |                                                                                             |                                                                                                |                                                                                                                                                                                                             |
| 29b. Signature and title of certifier<br><b>Theresa M. King</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                |                                                                                                                                                                                                                                                                                                          |                                                  | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                            |                                                           | 29d. Date signed (Month, Day, Year)<br><b>JUNE 29, 2000</b>                                 |                                                                                                |                                                                                                                                                                                                             |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Theresa M. King 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                |                                                                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                                                   |                                                           |                                                                                             |                                                                                                |                                                                                                                                                                                                             |
| 31. Date filed (Month, Day, Year)<br><b>JUL 05 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                          |                                                  |                                                                                                                                                                                                                   |                                                           |                                                                                             |                                                                                                |                                                                                                                                                                                                             |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22262

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Monagham

2. Date of Death

June 28 2000

3. Time of Death

2334

4a. Facility Name (If not institution, give street and number)

The Memorial Hospital

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

220-30-3552

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Oct. 18, 1922

9. Birthplace (State or Foreign Country)

Unknown

Usual Residence of Decedent

10a. State

Maryland

10b. County

Caroline

10c. City, Town or Location

Goldsboro

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

973 Bridge Town Rd.

10f. Zip Code

21636

10g. Citizen of What Country?

USA

11. Marital Status

Unknown

☐ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

☐ Yes ☐ No

If Yes, Give Year or Dates: Unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Carl Burke, Guardian

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

201 Talbot Blvd, Chestertown, Maryland 21620

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Capitol Crematory

Date

6/30/00

20c. Location - City or Town, State

Dover, Delaware

21. Signature of Funeral Service Licensee

D. H. Prince

22. Name and Address of Facility

Bennie Smith Funeral Home

P.O. Box 1687, Easton, Maryland 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Renal Failure

Due to (or as a consequence of):

b. Hypotension

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

15 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1) Acute Respiratory Distress Syndrome

2) Thrombocytopenia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dennis DeShields

29c. License number

D0053110

29d. Date signed (Month, Day, Year)

6/29/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis DeShields, MD, 219 South Washinton St., Easton, Maryland 21601

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

Dennis B. Sparks

Charles Monagham  
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22263

Amended line 17,18 fchd jd

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><b>SARAH ESTHER MEALEY</b>                                                                                                                                                                          |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   | 2. Date of Death<br>Month Day Year<br><b>JUNE 23, 2000</b>                                                                                                |                                                                    | 3. Time of Death<br><b>3:05 PM</b>                                                                 |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>                                                                                                                                            |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   | 4b. City, Town, or Location of Death<br><b>Frederick</b>                                                                                                  |                                                                    | 4c. County of Death<br><b>Frederick</b>                                                            |                                                             |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><b>578-22-9434</b>                                                                                                                                                                                                 |                                                                              | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.                                                                                                                                                  |                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 17, 1911</b>        |                                                                                                    | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                     |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                   |                                                                              | 10b. County<br><b>Frederick</b>                                                                                                                       |                                                                                                                              | 10c. City, Town or Location<br><b>Frederick</b>                                                                                                                                                   |                                                                                                                                                           |                                                                    | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br><b>1900 Rosemont Avenue</b>                                                                                                                                                                                           |                                                                              |                                                                                                                                                       |                                                                                                                              | 10f. Zip Code<br><b>21702</b>                                                                                                                                                                     |                                                                                                                                                           | 10g. Citizen of What Country?<br><b>United States</b>              |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                          |                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                              | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                           |                                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                            |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)                                                                                                                     |                                                                              |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Waitress</b> |                                                                                                                                                                                                   |                                                                                                                                                           | 16b. Kind of Business/Industry<br><b>Restaurant</b>                |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br><b>Charles Arthur Dyke</b>                                                                                                                                                                           |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Catherine Maurey</b>                                                                         |                                                                    |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth Conklyn, attorney</b>                                                                                                                                                          |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14 West Patrick St, Suite 200 Frederick, MD 21701</b> |                                                                    |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |                                                                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hagerstown Crematory</b>                                                 |                                                                                                                              | 20c. Date<br><b>6/26/00</b>                                                                                                                                                                       |                                                                                                                                                           | 20d. Location - City or Town, State<br><b>Hagerstown, Maryland</b> |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                   |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   | 22. Name and Address of Facility<br><b>Stauffer Funeral Homes, P.A.<br/>1621 Opossumtown Pike Frederick, Maryland 21702</b>                               |                                                                    |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CVA -</b>                        |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23b. Approximate Interval Between Onset and Death<br><b>1 WK</b>                                                                                                                                                                                |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 23c. Immediate Cause (Final disease or condition resulting in death)<br><b>CVA -</b>                                                                                                                                                            |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23d. Due to (or as a consequence of):                                                                                                                                                                                                           |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23e. Due to (or as a consequence of):                                                                                                                                                                                                           |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23f. Due to (or as a consequence of):                                                                                                                                                                                                           |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23g. Due to (or as a consequence of):                                                                                                                                                                                                           |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23h. Due to (or as a consequence of):                                                                                                                                                                                                           |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23i. Due to (or as a consequence of):                                                                                                                                                                                                           |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23j. Due to (or as a consequence of):                                                                                                                                                                                                           |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23k. Due to (or as a consequence of):                                                                                                                                                                                                           |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23l. Due to (or as a consequence of):                                                                                                                                                                                                           |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                                                                                                                                                                                 | 28a. Date of Injury (Month, Day, Year)                                       |                                                                                                                                                       | 28b. Time of Injury<br>M                                                                                                     |                                                                                                                                                                                                   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                      |                                                                    | 28d. Describe how injury occurred                                                                  |                                                             |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
| 29b. Signature and Title of Certifier<br>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                              | 29c. License number<br><b>D-13971</b>                                                                                                                                                             |                                                                                                                                                           | 29d. Date signed (Month, Day, Year)<br><b>6/25/00</b>              |                                                                                                    |                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Robert L. Kaufmann 310 W. 9th Street Frederick, MD</b>                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>2000 27 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                              | 32. Registrar's Signature<br>                                                                                                                                                                     |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                 |                                                                              |                                                                                                                                                       |                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                           |                                                                    |                                                                                                    |                                                             |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22264

Amended item#17 FCHD 06/29/2000 KS Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret Vivian Meetze

2. Date of Death

Month Day Year  
June 18, 2000

3. Time of Death

6:30 AM

4a. Facility Name (If not institution, give street and number)

Sunrise Assisted Living

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

223-60-7877

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 13, 1909

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

990 Waterford Drive

10f. Zip Code

21702

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Self

16b. Kind of Business/Industry

Homemaker

17. Father's Name (First, Middle, Last)

Napoleon Meetze Napoleon Alford

18. Mother's Name (First, Middle, Maiden Summa)

Maude Bates

19a. Informant's Name/Relationship (Type, Print)

Henry Meetze, son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2424 Stoney Creek Road, Frederick, MD 21701

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem.

Date

6/28/2000 Arlington, Virginia

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ryan M. Berger

22. Name and Address of Facility

MO0999 Keeney and Basford Funeral Home  
106 East Church Street, Frederick, Maryland 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Malnutrition

Due to (or as a consequence of):

b. Cerebral Vascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 Months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Assisted Living

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert M. Scovner

29c. License number

D14724

29d. Date signed (Month, Day, Year)

June 20 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Scovner M.D. 1603 B Berry Rose Court, Frederick MD.

31. Date filed (Month, Day, Year)

JUN 21 2000

32. Registrar's Signature

B. Spaw

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 800-668-6868.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22265

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BETTY ANN MYERS

2. Date of Death

Month Day Year  
June 28 2000

3. Time of Death

12:40 p.m.

4a. Facility Name (If not institution, give street and number)

2717 Milt Summers Road

4b. City, Town, or Location of Death

Middletown

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

216-30-3798

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 4, 1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Middletown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

2717 Milt Summers Road

10f. Zip Code

21769

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Dairy Farm

17. Father's Name (First, Middle, Last)

Ernest Smith

18. Mother's Name (First, Middle, Maiden Surname)

Mary Viola Bear

19a. Informant's Name/Relationship (Type, Print)

Charles O. Myers/spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2717 Milt Summers Road, Middletown, MD 21769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion U. Methodist Cemt. 6-30-00

Date

20c. Location - City or Town, State

Myersville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

504 Main Street  
Ricketts Funeral Home Myerville, MD 21773

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ovarian Carcinoma  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

13 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

A23623

29d. Date signed (Month, Day, Year)

June 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederic H. Koss, MD 1110 Medical Campus Rd Hagerstown Md

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22266

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

Lynn Brenneman Mowers

2. Date of Death

Month Day Year  
June 28, 2000

3. Time of Death

11:35 AM

4a. Facility Name (If not institution, give street and number)

Williamsport Nursing Home

4b. City, Town, or Location of Death

Williamsport

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

180-10-6819

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 21, 1906 PA.

9. Birthplace (State or Foreign Country)

Usual Residence of Decedant

10a. State

MD.

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

11 W. Baltimore St.

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

delivery person

16b. Kind of Business/Industry

retail co.

17. Father's Name (First, Middle, Last)

Charles Edgar Mowers

18. Mother's Name (First, Middle, Maiden Surname)

Emma Brenneman

19a. Informant's Name/Relationship (Type, Print)

Joanne F. Ryan (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 Birch Knoll Rd., Hagerstown, MD. 21742

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lutheran Cemetery

Date

7/1

20c. Location - City or Town, State

Middletown, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donald B. Thompson Funeral Home  
31 E. Main St., Middletown, MD. 2176923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. RECURRENT ASPIRATION PNEUMONIA

Approximate  
Interval Between  
Onset and Death

WEEKS

Due to (or as a consequence of):

b. DYSPHAGIA

Due to (or as a consequence of):

c. MULTIPLE CEREBRAL INFARCTS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28e. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D33700

29d. Date signed (Month, Day, Year)

JUNE 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TED HOWE MD 7542 OVERLOOK DR. BOONSBORO, MD 21713

31. Date filed (Month, Day, Year)

JUL 03 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22267

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                     |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br>James Jewell McElwain                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br>June 27, 2000                                                                                                              |                                                                              | 3. Time of Death<br>6:20 am                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br>35 West Frederick Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>Walkersville                                                                                                             |                                                                              | 4c. County of Death<br>Frederick                                                                                                                                                                    |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br>170-12-7323                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br>78 Yrs.                                                                                                                        | 8. Date of Birth (Month, Day, Year)<br>May 21, 1922                          | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                     |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                              | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 10b. County<br>Frederick                                                                                                                                                                                                                                                                                | 10c. City, Town or Location<br>Walkersville                                                                                                                      |                                                                              | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10e. Street and Number<br>35 West Frederick Street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         | 10f. Zip Code<br>21793                                                                                                                                           |                                                                              | 10g. Citizen of What Country?<br>U.S.A.                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1943-<br>If Yes, Give Year or Dates: 1945 |                                                                              | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                         | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+                                            |                                                                              |                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Administration - V.P.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         | 16b. Kind of Business/Industry<br>Moving/Storage Company                                                                                                         |                                                                              |                                                                                                                                                                                                     |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                    | 17. Father's Name (First, Middle, Last)<br>Charles Lester McElwain                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         | 18. Mother's Name (First, Middle, Maiden Surname)<br>Virginia May Estep                                                                                          |                                                                              |                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs Ruth Nelson McElwain/Wife                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>35 West Frederick Street, Walkersville, MD 21793                |                                                                              |                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St John's Cemetery                                                                     |                                                                              | 20c. Location - City or Town, State<br>Frederick, Maryland                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. Signature of Funeral Service Licensee<br>[Signature] MO0706                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         | 22. Name and Address of Facility<br>Keeney & Basford P.A. Funeral Home<br>106 East Church St, Frederick, Maryland 21701                                          |                                                                              |                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <u>BREAST CANCER</u><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |                                                                                                                                                                                                                                                                                                         | Approximate Interval Between Onset and Death<br>4 years                                                                                                          |                                                                              |                                                                                                                                                                                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>HYPOERTENSION</u><br><u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                     |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                               |                                                                                                                                                                  |                                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                         |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                     |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 28a. Date of Injury (Month, Day Year)<br>M                                                                                                                                                                                                                                                              |                                                                                                                                                                  | 28b. Time of Injury<br>M                                                     |                                                                                                                                                                                                     |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                       |                                                                                                                                                                  | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                                                                                     |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                     |
| 29b. Signature and title of certifier<br>[Signature] MD                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 29c. License number<br>D3271                                                                                                                                                                                                                                                                            |                                                                                                                                                                  | 29d. Date signed (Month, Day, Year)<br>6/27/06                               |                                                                                                                                                                                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Richard L. Gough, M.D., 19 West Frederick Street, Walkersville, Maryland 21793                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                     |
| 31. Date filed (Month, Day, Year)<br>JUN 28 2000                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 32. Registrar's Signature<br>[Signature] B. Sparks                                                                                                                                                                                                                                                      |                                                                                                                                                                  |                                                                              |                                                                                                                                                                                                     |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 22268

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                              |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1. Decedent's Name (First, Middle, Last)<br><b>Roby Myers Jr.</b>                                              |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <b>June</b> Day <b>25</b> Year <b>2000</b> |                                                                                                                                                                                              | 3. Time of Death<br><b>5<sup>52</sup> AM</b> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4a. Facility Name (If not institution, give street and number)<br><b>University of Maryland Medical System</b> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>             |                                                                                                                                                                                              | 4c. County of Death                          |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 5. Social Security Number<br><b>188-32-3396</b>                                                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.                     | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 8. Date of Birth<br>Month, Day, Year<br><b>MAR. 9, 1942</b>                                                    |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>               |                                                                                                                                                                                              |                                              |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                              |
| 10a. State<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                | 10b. County<br><b>FREDERICK</b>                                                                                                                                                                                                                                                             |                                                                      | 10c. City, Town or Location<br><b>FREDERICK</b>                                                                                                                                              |                                              |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                              |
| 10e. Street and Number<br><b>10 TANEY APT.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                | 10f. Zip Code<br><b>21701</b>                                                                                                                                                                                                                                                               |                                                                      | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                               |                                              |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                              |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                              |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10 TH</b><br>College (1-4 or 5+) <b>PAINTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PAINTER</b>                                                                                                                                                                 |                                                                      | 16b. Kind of Business/Industry<br><b>HOME IMPROVEMENT</b>                                                                                                                                    |                                              |
| 17. Father's Name (First, Middle, Last)<br><b>ROBY R. MYERS SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CATHERINE BUTLER</b>                                                                                                                                                                                                                |                                                                      |                                                                                                                                                                                              |                                              |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ALVERTA V. MYERS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3 SOUTH PENDLETON COURT FRED. MD. 21701</b>                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                              |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FAIRVIEW CEM.</b>                                                                                                                                                                                              |                                                                      | 20c. Location - City or Town, State<br><b>JUNE 30, 2000 fred. md</b>                                                                                                                         |                                              |
| 21. Signature of Funeral Service Licensee<br><b>Gary L. Feltis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                | 22. Name and Address of Facility<br><b>GARY L. ROLLINS FUNERAL HOME<br/>110 WEST SOUTH ST FRED. MD. 21701</b>                                                                                                                                                                               |                                                                      |                                                                                                                                                                                              |                                              |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><b>a. Pulmonary mucormycosis</b><br>Due to (or as a consequence of):<br><b>b. Immunosuppression Secondary to Kidney transplant</b><br>Due to (or as a consequence of):<br><b>c. End Stage Renal Disease</b><br>Due to (or as a consequence of):<br><b>d. Coronary Artery Disease</b> |                                                                                                                | Approximate Interval Between Onset and Death<br><b>3 weeks</b><br><b>3 months</b><br><b>18 years</b><br><b>18 years</b>                                                                                                                                                                     |                                                                      |                                                                                                                                                                                              |                                              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |                                                                      |                                                                                                                                                                                              |                                              |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                                      |                                                                                                                                                                                              |                                              |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                      |                                                                                                                                                                                              |                                              |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                      | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                              |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                       |                                              |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                              |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                                                      |                                                                                                                | 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                 |                                                                      | 29c. License number<br><b>09448</b>                                                                                                                                                          |                                              |
| 29d. Date signed (Month, Day, Year)<br><b>June 26 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dominic Coletti 22 South Greene Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                              |
| 31. Date filed (Month, Day, Year)<br><b>JUL 07 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                                                              |                                              |





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State of Maryland / Department of Health and Mental Hygiene

00 22269

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Howard M. Mainhart</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                               |  | 2. Date of Death<br>Month Day Year<br><b>June 25, 2000</b>                                                                                                                                                                                                                                              |  | 3. Time of Death<br><b>9:30 a.m.</b>                                                 |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>College View Center</b>                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                               |  | 4b. City, Town, or Location of Death<br><b>Frederick</b>                                                                                                                                                                                                                                                |  | 4c. County of Death<br><b>Frederick</b>                                              |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-14-6320</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                |  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.                                                                                                                                                                                                                                                        |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 19, 1917</b>                          |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                   |  | 10a. State<br><b>Maryland</b>                                                                                                                                                                 |  | 10b. County<br><b>Frederick</b>                                                                                                                                                                                                                                                                         |  | 10c. City, Town or Location<br><b>Frederick</b>                                      |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |  | 10e. Street and Number<br><b>700 College Ave</b>                                                                                                                                              |  | 10f. Zip Code<br><b>21701</b>                                                                                                                                                                                                                                                                           |  | 10g. Citizen of What Country?<br><b>USA</b>                                          |  |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                        |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                         |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                        |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>4</b>                                                                                                                                                                                                                                                                                                |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>mortgage broker</b>                                                           |  | 16b. Kind of Business/Industry<br><b>real estate</b>                                                                                                                                                                                                                                                    |  |                                                                                      |  |
|                                               | 17. Father's Name (First, Middle, Last)<br><b>Lester Grayson Mainhart</b>                                                                                                                                                                                                                                                                                                                                                     |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rebecca Morsell</b>                                                                                                                   |  | 19. Informant's Name/Relationship (Type, Print)<br><b>Deborah Mainhart, daughter</b>                                                                                                                                                                                                                    |  |                                                                                      |  |
| Physician<br>/Medical<br>Examiner             | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                               |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>                                                                                         |  | 20c. Date<br><b>6/27/2000</b>                                                                                                                                                                                                                                                                           |  | 20d. Location - City or Town, State<br><b>Smithsburg, Maryland</b>                   |  |
|                                               | 21. Signature of Funeral Service Licensee<br><b>Ryan M. Beyer</b>                                                                                                                                                                                                                                                                                                                                                             |  | 22. Name and Address of Facility<br><b>Keeney and Basford Funeral Home</b>                                                                                                                    |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cardio myopathy</b>                                                                     |  |                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Renal failure</b>                                                                                                                                                                                                                                                                           |  | 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                               |  |                                                                                      |  |
|                                               | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                        |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                         |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                        |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                               | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                             |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                        |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |  |                                                                                      |  |
| State<br>Registrar                            | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><b>Allen Hettlemann</b>                                                                                                                              |  | 29c. License number<br><b>D27569</b>                                                                                                                                                                                                                                                                    |  | 29d. Date signed (Month, Day, Year)<br><b>6/27/00</b>                                |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Allen Hettlemann 1838 Greene Tree Rd #300</b>                                                                                                                                                                                                                                                                                      |  | 31. Date filed (Month, Day, Year)<br><b>JUN 29 2000</b>                                                                                                                                       |  | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                                                                                                                                                                           |  |                                                                                      |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

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State of Maryland / Department of Health and Mental Hygiene

00 22270

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                  |                                                           |                                                                                                                                                                                              |                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                               | 1. Decedent's Name (First, Middle, Last)<br><b>Elva Mae Nichols</b>                            |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                  | 2. Date of Death<br>Month Day Year<br><b>June 25 2000</b> |                                                                                                                                                                                              | 3. Time of Death<br><b>1015</b>                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4e. Facility Name (If not institution, give street and number)<br><b>The Memorial Hospital</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br><b>Easton</b>     |                                                                                                                                                                                              | 4c. County of Death<br><b>Talbot</b>                        |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                             | 5. Social Security Number<br><b>216-14-2037</b>                                                |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.          |                                                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 28, 1924</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>Maryland</b>                                              |                                                                                                                                                                                                  | 10b. County<br><b>Talbot</b>                              |                                                                                                                                                                                              | 10c. City, Town or Location<br><b>Easton</b>                |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                              |                                                                            | 10e. Street and Number<br><b>995 Washington Street</b>                                                                                                                                           |                                                           | 10f. Zip Code<br><b>21601</b>                                                                                                                                                                |                                                             |  |
| 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                              |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                |                                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                             |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)                                                                                                                                                                 |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Home Maker</b>                                                                   |                                                           | 16b. Kind of Business/Industry<br><b>Some one else's home</b>                                                                                                                                |                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Chester</b>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Maggie Bolden</b>                                                                                                                        |                                                           |                                                                                                                                                                                              |                                                             |  |
| 19. Informant's Name/Relationship (Type, Print)<br><b>Faith Roberts / Daughter</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10750 Lewistown Road, Cordova, Maryland 21625</b>                                            |                                                           |                                                                                                                                                                                              |                                                             |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                           |                                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Richards Cemetery</b>                                                                                                                                                                                          |                                                                            | 20c. Date<br><b>6/28/2000</b>                                                                                                                                                                    |                                                           | 20d. Location - City or Town, State<br><b>Easton, Maryland</b>                                                                                                                               |                                                             |  |
| 21. Signature of Funeral Service Licensee<br><b>John A. Prince</b>                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>Bennie Smith Funeral Home<br/>P.O. Box 1687, Easton, Maryland 21601</b>                                                                                   |                                                           |                                                                                                                                                                                              |                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                | a. <b>Respiratory failure</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                           |                                                                            | b. <b>probable pulmonary emboli</b><br>Due to (or as a consequence of):                                                                                                                          |                                                           | c.<br>Due to (or as a consequence of):                                                                                                                                                       |                                                             |  |
| d.<br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                | Approximate Interval Between Onset and Death<br><b>2 days</b>                                                                                                                                                                                                                               |                                                                            | Approximate Interval Between Onset and Death<br><b>3 days</b>                                                                                                                                    |                                                           |                                                                                                                                                                                              |                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Aortic aneurysm</b><br><b>Chronic obstructive pulmonary disease</b>                                                                                                                                                                                                                                                |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                           |                                                                                                                                                                                              |                                                             |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                           |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                     |                                                                            |                                                                                                                                                                                                  |                                                           |                                                                                                                                                                                              |                                                             |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                                | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                                  |                                                           |                                                                                                                                                                                              |                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                      |                                                                                                | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                            | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                             |                                                             |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                           |                                                                                                                                                                                              |                                                             |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                       |                                                                                                | 29b. Signature and title of certifier<br><b>Harou Laura Jin</b>                                                                                                                                                                                                                             |                                                                            | 29c. License number<br><b>D0055484</b>                                                                                                                                                           |                                                           | 29d. Date signed (Month, Day, Year)<br><b>06-25-2000</b>                                                                                                                                     |                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Harou Laura Jin, M D, 219 South Washinton Street, Easton, Maryland 21601</b>                                                                                                                                                                                                                                                                         |                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                  |                                                           |                                                                                                                                                                                              |                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 28 2000</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                  |                                                           |                                                                                                                                                                                              |                                                             |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22271

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                          | 1. Decedent's Name (First, Middle, Last)<br><b>Marvin Nelson</b>                                     |                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>June 23 2000</b> |                                                                                                                                                                                                                                                                                                                                                                                                                           | 3. Time of Death<br><b>222 am</b>                    |  |
|                                                                                                                                                                                                                                                                            | 4a. Facility Name (If not institution, give street and number)<br><b>Peninsula Regional Hospital</b> |                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Salisbury</b>  |                                                                                                                                                                                                                                                                                                                                                                                                                           | 4c. County of Death<br><b>Wicomico</b>               |  |
| Funeral<br>Director                                                                                                                                                                                                                                                        | 5. Social Security Number<br><b>216-56-0884</b>                                                      |                                                                                                                                                                                                                                                                        | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs.          |                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><b>5-1-53</b> |  |
|                                                                                                                                                                                                                                                                            | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>                                               |                                                                                                                                                                                                                                                                        | 10a. State<br><b>MD.</b>                                                   |                                                                                                                                                                                              | 10b. County<br><b>Worcester</b>                           |                                                                                                                                                                                                                                                                                                                                                                                                                           | 10c. City, Town or Location<br><b>Snow Hill</b>      |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                             |                                                                                                      | 10e. Street and Number<br><b>412 West Market Street</b>                                                                                                                                                                                                                |                                                                            | 10f. Zip Code<br><b>21864</b>                                                                                                                                                                |                                                           | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                            |                                                      |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                             |                                                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                      |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                                                                                                                                                   |                                                      |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b>                                                                                                                                                           |                                                                                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic Worker</b>                                                                                                                                    |                                                                            | 16b. Kind of Business/Industry<br><b>Housekeeping</b>                                                                                                                                        |                                                           | 17. Father's Name (First, Middle, Last)<br><b>Rollie John Nelson Sr.</b>                                                                                                                                                                                                                                                                                                                                                  |                                                      |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ella Mae Wright</b>                                                                                                                                                                                                |                                                                                                      | 19a. Informant's Name/Relationship (Type, Print)<br><b>Avery Nelson Sr. (Brother)</b>                                                                                                                                                                                  |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1012 Clark Avenue Pocomoke City, Md. 21851</b>                                           |                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                      |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Georgetown Cemetery</b>                                                                                                                                                                       |                                                                                                      | 20c. Date<br><b>7-1-00</b>                                                                                                                                                                                                                                             |                                                                            | 20d. Location - City or Town, State<br><b>Pocomoke Md. 21851</b>                                                                                                                             |                                                           | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                             |                                                      |  |
| 22. Name and Address of Facility<br><b>Bennie Smith Funeral Home<br/>P.O. Box 331 Pocomoke Md. 21851</b>                                                                                                                                                                   |                                                                                                      | 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> |                                                                            | 23b. Approximate Interval Between Onset and Death                                                                                                                                            |                                                           | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                          |                                                      |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                      |                                                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                     |                                                                            | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                            |                                                           | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |                                                      |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |                                                                                                      | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                 |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                      |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                          |                                                                                                      | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                           |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                           | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                      |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                  |                                                                                                      | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                 |                                                                            | 29d. Date signed (Month, Day, Year)<br><b>June 24, 2000</b>                                                                                                                                  |                                                           | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>THEODOR H. KING 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                 |                                                      |  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 27 2000</b>                                                                                                                                                                                                                    |                                                                                                      | 32. Registrar's Signature<br>                                                                                                                                                                                                                                          |                                                                            | 33. State Registrar                                                                                                                                                                          |                                                           | 34. State Registrar                                                                                                                                                                                                                                                                                                                                                                                                       |                                                      |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

00 22272

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                |                                                                                                                                                                                                                                                                                                                                             |                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1. Decedent's Name (First, Middle, Last)<br><b>MARTHA OWENS</b>                              |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                           | 2. Date of Death<br>Month Day Year<br><b>June 26, 2000</b>     |                                                                                                                                                                                                                                                                                                                                             | 3. Time of Death<br><b>9:30PM</b>                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4a. Facility Name (If not institution, give street and number)<br><b>6801 Bock Road #445</b> |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                           | 4b. City, Town, or Location of Death<br><b>Fort Washington</b> |                                                                                                                                                                                                                                                                                                                                             | 4c. County of Death<br><b>Prince George's</b>                   |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 5. Social Security Number<br><b>239 32 5391</b>                                              |                                                                                                                                                   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                           | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.               |                                                                                                                                                                                                                                                                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>December 22, 1929</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 9. Birthplace (State or Foreign Country)<br><b>N. Carolina</b>                               |                                                                                                                                                   | 10a. State<br><b>Maryland</b>                                              |                                                                                                                                                                                                                                                                                                                                                                                                                           | 10b. County<br><b>Prince George's</b>                          |                                                                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>Fort Washington</b>           |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              | 10e. Street and Number<br><b>6801 Bock Road #445</b>                                                                                              |                                                                            | 10f. Zip Code<br><b>20744</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                                                                                 |                                                                 |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                             |                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                                                                     |                                                                 |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic</b>                      |                                                                            | 16b. Kind of Business/Industry<br><b>Private</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                | 17. Father's Name (First, Middle, Last)<br><b>Clarence Sumler</b>                                                                                                                                                                                                                                                                           |                                                                 |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Elizabeth Turner</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              | 19a. Informant's Name/Relationship (Type, Print)<br><b>Cynthia Walters /daughter</b>                                                              |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2120 Alice Avenue #1 Oxon Hill, MD 20745</b>                                                                                                                                                                                                                                                                          |                                                                | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                       |                                                                 |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glenwood Cemetery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              | 20c. Location - City or Town, State<br><b>7-1 Washington D.C.</b>                                                                                 |                                                                            | 21. Signature of Funeral Service Licensee<br><i>Amberley C. Briscoe Tonic</i>                                                                                                                                                                                                                                                                                                                                             |                                                                | 22. Name and Address of Facility<br><b>MARSHALL'S FUNERAL HOME OF MD<br/>4308 Suitland Road Suitland, MD 20746</b>                                                                                                                                                                                                                          |                                                                 |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CORONARY ARTERY DISEASE</b><br><b>b. CONGESTIVE HEART FAILURE</b><br><b>c.</b><br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>DIABETES MELLITUS</b> |                                                                                              | Approximate Interval Between Onset and Death<br><b>5 YEARS</b><br><b>5 YEARS</b>                                                                  |                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |                                                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                       |                                                                 |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                 |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |                                                                | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                  |                                                                 |  |
| 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              | 28b. Time of Injury<br><b>M</b>                                                                                                                   |                                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                           |                                                                 |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |                                                                            | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                | 29b. Signature and title of certifier<br><b>V. Singh Attend Phys.</b>                                                                                                                                                                                                                                                                       |                                                                 |  |
| 29c. License number<br><b>D 18897</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              | 29d. Date signed (Month, Day, Year)<br><b>6.27.00</b>                                                                                             |                                                                            | 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>V. SINGH 7209 A HAROVER PARKWAY GREENBELT MD 20770</b>                                                                                                                                                                                                                                                                         |                                                                | 31. Date filed (Month, Day, Year)<br><b>JUN 30 2000</b>                                                                                                                                                                                                                                                                                     |                                                                 |  |
| 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              | 33. Registrar<br><b>State Registrar</b>                                                                                                           |                                                                            | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020                                                                                                                                                                                                                                                                                                                                             |                                                                | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card. |                                                                 |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22273

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bethel D. Owens

2. Date of Death

Month

Day

Year

JUNE 26, 2000

3. Time of Death

5:31 A.M.

4a. Facility Name (If not institution, give street and number)

Mercy Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

Funeral  
Director

5. Social Security Number

040 05 4142

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

January 3, 1917

9. Birthplace (State or Foreign Country)

Connecticut

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Jessup

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

8209 Cambridge Court

10f. Zip Code

20794

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Statistical Clerk

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Samuel Dillon

18. Mother's Name (First, Middle, Maiden Summa)

Anna Colley

19a. Informant's Name/Relationship (Type, Print)

Larry Owens

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8108 Sheffield Court Jessup Maryland 20784

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Fort Lincoln Crematory

Data

6/28/2000

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Sham E. Williams

22. Name and Address of Facility

Fort Lincoln funeral Home

3401 Bladensburg Road Brentwood Maryland 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. HEPATIC FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. METASTATIC OVARIAN CANCER

Due to (or as a consequence of):

7 MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)29. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William P. McSwain

29c. License number

D16801

29d. Date signed (Month, Day, Year)

06/26/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301 ST. PAUL PLACE BALTIMORE, MD 21202

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

Barbara B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(5)

0001 B S KUL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


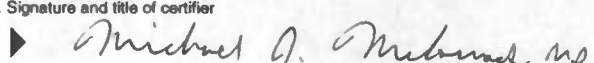
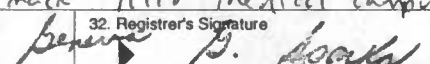
State of Maryland / Department of Health and Mental Hygiene

00 22274

amend item 20b,c, per fh G785 7/21/00 yg

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |                                                    |                                                                                                                                                                                                          |                                                                                                    |                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br>Allene Lane Olmo                                 |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     | 2. Date of Death<br>Month Day Year<br>June 21 2000 |                                                                                                                                                                                                          | 3. Time of Death<br>1830                                                                           |                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     | 4b. City, Town, or Location of Death<br>Hagerstown |                                                                                                                                                                                                          | 4c. County of Death<br>Washington                                                                  |                                                         |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br>430 80 7088                                                     | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br>54 Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                                      | If Under 24 Hrs.<br>Hours Min.                     | 8. Date of Birth (Month, Day, Year)<br>July 20, 1945                                                                                                                                                     |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Michigan    |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Usual Residence of Decedent                                                                  |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |                                                    |                                                                                                                                                                                                          |                                                                                                    |                                                         |
| 10a. State<br>WV                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              | 10b. County<br>Morgan                                                                                                                                                                                                                                                                                   |                                           | 10c. City, Town or Location<br>Berkeley Springs                                                                                                                                                     |                                                    |                                                                                                                                                                                                          | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                         |
| 10e. Street and Number<br>105 Woodside Drive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                           | 10f. Zip Code<br>25411                                                                                                                                                                              |                                                    | 10g. Citizen of What Country?<br>U.S.A.                                                                                                                                                                  |                                                                                                    |                                                         |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                    |                                                                                                                                                                                                          | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                                         |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 2 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Lab technician                                                                         |                                                    |                                                                                                                                                                                                          | 16b. Kind of Business/Industry<br>Printing                                                         |                                                         |
| 17. Father's Name (First, Middle, Last)<br>Joseph Sebring                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                           | 18. Mother's Name (First, Middle, Maiden Surname)<br>Nora Allene Lane                                                                                                                               |                                                    |                                                                                                                                                                                                          |                                                                                                    |                                                         |
| 19a. Informant's Name/Relationship (Type, Print)<br>Valerie C. Olmo                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>105 Woodside Drive, Berkeley Springs, WV 25411                                                     |                                                    |                                                                                                                                                                                                          |                                                                                                    |                                                         |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Greenwood Grove Cemetery<br>Hagerstown Crematory                                                                                                                                                                              |                                           | Date<br>6/23/2000                                                                                                                                                                                   |                                                    | 20c. Location - City or Town, State<br>Unger, WV<br>Hagerstown, Md                                                                                                                                       |                                                                                                    |                                                         |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              | MO0522                                                                                                                                                                                                                                                                                                  |                                           | 22. Name and Address of Facility<br>Helsley-Johnson Funeral Home, Inc.<br>306 Union St., Berkeley Springs, WV 25411-1837                                                                            |                                                    |                                                                                                                                                                                                          |                                                                                                    |                                                         |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Non Hodgkin's Lymphoma</u><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |                                                    |                                                                                                                                                                                                          |                                                                                                    | Approximate Interval Between Onset and Death<br>7 years |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |                                                    | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                                                                    |                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |                                                    | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                                                                    |                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |                                                    | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                                                                                    |                                                         |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                           |                                                                                                                                                                                                     |                                                    |                                                                                                                                                                                                          |                                                                                                    |                                                         |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                          |                                                                                              | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                           | 28b. Time of Injury<br>M                                                                                                                                                                            |                                                    | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                                                                                                    | 28d. Describe how injury occurred                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                           |                                                                                                                                                                                                     |                                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                             |                                                                                                    |                                                         |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                      |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |                                                    |                                                                                                                                                                                                          |                                                                                                    |                                                         |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                           | 29c. License number<br>D 91667                                                                                                                                                                      |                                                    | 29d. Date signed (Month, Day, Year)<br>6-22-00                                                                                                                                                           |                                                                                                    |                                                         |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Michael McCormack 1110 Medical Campus Rd. Hagerstown MD 21742                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                           |                                                                                                                                                                                                     |                                                    |                                                                                                                                                                                                          |                                                                                                    |                                                         |
| 31. Date filed (Month, Day, Year)<br>JUL 03 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              | 32. Registrar's Signature<br>                                                                                                                                                                                        |                                           |                                                                                                                                                                                                     |                                                    |                                                                                                                                                                                                          |                                                                                                    |                                                         |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 22275

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Gino L. Piperni

2. Date of Death  
Month Day Year  
June 28, 2000

3. Time of Death  
5:35 PM

4a. Facility Name (If not institution, give street and number)

Fort Washington Hospital

4b. City, Town, or Location of Death

Ft. Washington

4c. County of Death

Prince Georges

5. Social Security Number

579-07-6317

6. Sex  
1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)

Nov. 18, 1920

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Temple Hills

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

2010 Gaither Street

10f. Zip Code

20748

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Builder

16b. Kind of Business/Industry

Building/Construction

17. Father's Name (First, Middle, Last)

Fabrizio Piperni

18. Mother's Name (First, Middle, Maiden Surname)

Margarhite Unknown

19a. Informant's Name/Relationship (Type, Print)

Robert L. Piperni/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9800 Kiskonko Rd., Ft. Wahington, MD 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Resurrection Cemetery

Date

7/3/2000

20c. Location - City or Town, State

Clinton, MD

21. Signature of Funeral Service Licensee

*George P. Kalas*

22. Name and Address of Facility

George P. Kalas Funeral Home, P.A.

6160 Oxon Hill Rd., Oxon Hill, MD 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a.

PNEUMONIA  
Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

DAYS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CORONARY ARTERY DISEASE

PARKINSON'S DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury  
(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

*John*

29c. License number

D12906

29d. Date signed (Month, Day, Year)

6/29/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Louis Kaufman 12070 Old Line Center Waldorf, Md 20602

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

*Benita B. Smith*

State  
Registrar

Baltimore, Maryland 21215-0020

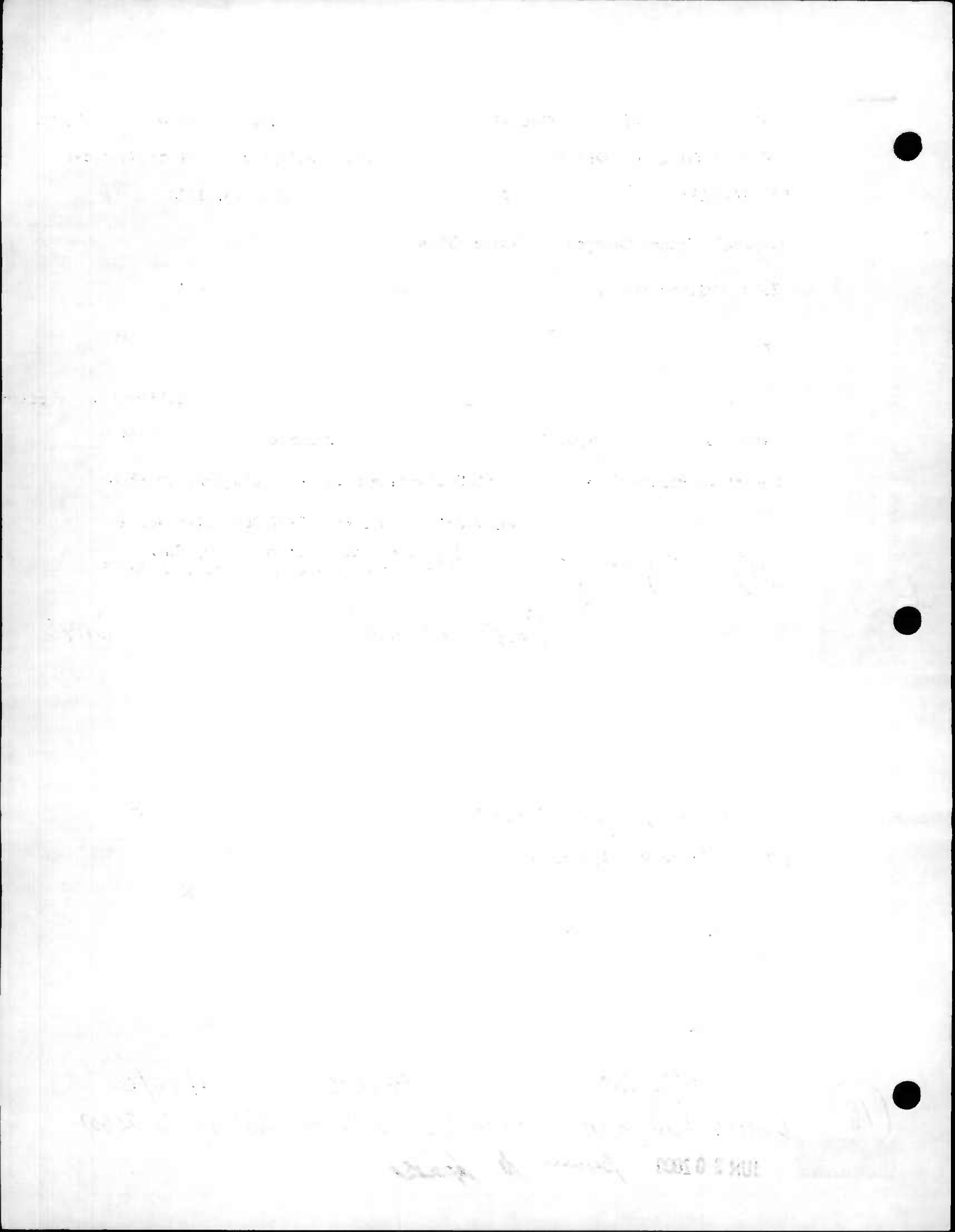
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22276

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Doris Peyton

2. Date of Death

Month

Day

Year

6

21

2000

3. Time of Death

2:07 pm

4a. Facility Name (If not institution, give street and number)

DOCTOR'S HOSPITAL

4b. City, Town, or Location of Death

Lanham

4c. County of Death

P.G.

Funeral  
Director

5. Social Security Number

578-40-6083

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

3-3-23

9. Birthplace (State or Foreign Country)

Cliffside, NC

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Greenbelt

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9166 Springhill Lane

10f. Zip Code

20710

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Georgetown Hospital

17. Father's Name (First, Middle, Last)

Benjamin Mercer

18. Mother's Name (First, Middle, Maiden Summa)

Isabella McElrath

19a. Informant's Name/Relationship (Type, Print)

Carolyn Lewis - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9166 Springhill Lane Greenbelt, Md 20710

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cheltenham Cemetery

Date

6/27/00

20c. Location - City or Town, State

Cheltenham, Md

21. Signature of Funeral Service Licensee

Lisa A. Henry M01178

22. Name and Address of Facility

B.K. Henry Funeral Chapel, Inc.

420 H Street, NE Washington, DC 20002

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute renal failure

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Congestive Heart Failure

Due to (or as a consequence of):

6 mos.

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

anidous

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Granite MD

29c. License number

D17572

29d. Date signed (Month, Day, Year)

6/29/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. Granite, M.D., 115 Centerway Rd Greenbelt MD 20770

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

B. A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

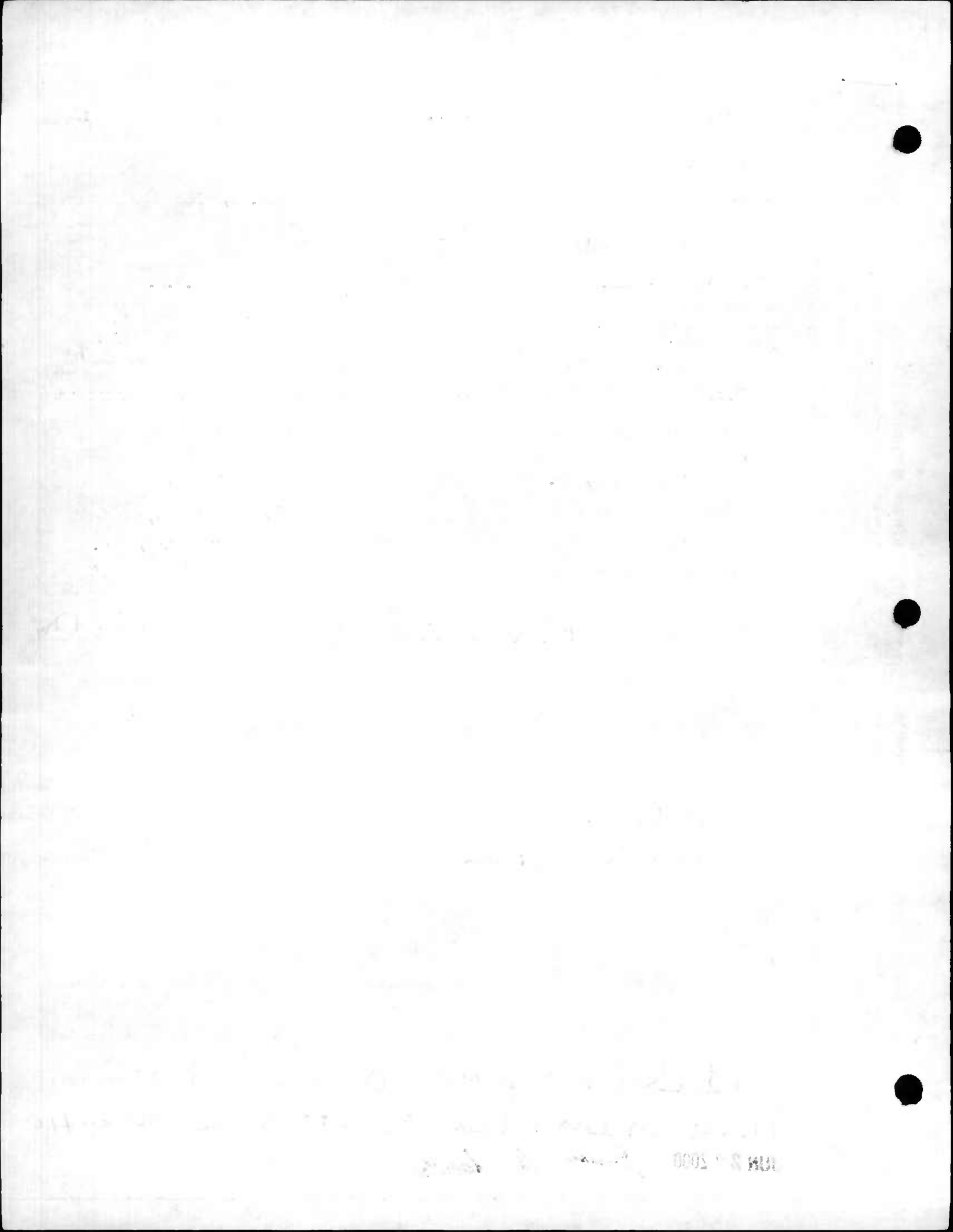
## Certificate of Death

Reg. No.

00 22277

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                             |                                                                                                                                                                                                   |                                         |                                                                                      |                                                                                                                                                                                                          |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Warren Clayton Perry, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                             | 2. Date of Death<br>Month Day Year<br>June 20, 2000                                                                                                                                               |                                         | 3. Time of Death<br>6:50AM                                                           |                                                                                                                                                                                                          |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>Washington Adventist Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                             | 4b. City, Town, or Location of Death<br>Takoma Park                                                                                                                                               |                                         | 4c. County of Death<br>Montgomery                                                    |                                                                                                                                                                                                          |
| Funeral<br>Director                           | 5. Social Security Number<br>579-46-9548                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>63 Yrs.                                                                                                                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br>Oct. 4, 1936                                                                                         | 9. Birthplace (State or Foreign Country)<br>Washington DC                                                                                                                                         |                                         |                                                                                      |                                                                                                                                                                                                          |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                             |                                                                                                                                                                                                   |                                         |                                                                                      |                                                                                                                                                                                                          |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 10b. County<br>Prince George's                                             | 10c. City, Town or Location<br>Hyattsville                                                                                                                                                                                                                                                              |                                                                                                                                             | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                         |                                                                                      |                                                                                                                                                                                                          |
|                                               | 10e. Street and Number<br>7105 Glenridge Drive                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                                         | 10f. Zip Code<br>20784                                                                                                                      |                                                                                                                                                                                                   | 10g. Citizen of What Country?<br>U.S.A. |                                                                                      |                                                                                                                                                                                                          |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                         | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                     |                                                                                                                                                                                                          |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary (Secondary (0-12))<br>12th                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>N/A College (1-4 or 5+)<br>Nursing Assistant                                                                                                                                               |                                                                                                                                             | 16b. Kind of Business/Industry<br>Federal Government                                                                                                                                              |                                         |                                                                                      |                                                                                                                                                                                                          |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br>John Edward Perry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                                         | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dorothy Pauline Brown                                                                  |                                                                                                                                                                                                   |                                         |                                                                                      |                                                                                                                                                                                                          |
|                                               | 19a. Informant's Name/Relationship (Type, Print)<br>Warren Clayton Perry, Jr. (Son)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                         | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7105 Glenridge Drive Hyattsville, MD 20784 |                                                                                                                                                                                                   |                                         |                                                                                      |                                                                                                                                                                                                          |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                 |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lee Crematory                                                                                                                                                                                                                 |                                                                                                                                             | 20c. Location - City or Town, State<br>Clinton, Maryland                                                                                                                                          |                                         | 20d. Date<br>June 22, 2000                                                           |                                                                                                                                                                                                          |
|                                               | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                         | 22. Name and Address of Facility<br>Lee Funeral Home, Inc.<br>6633 Old Alexandria Ferry Road Clinton, MD 20735                              |                                                                                                                                                                                                   |                                         |                                                                                      |                                                                                                                                                                                                          |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Pneumonia</u><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                             |                                                                                                                                                                                                   |                                         |                                                                                      | Approximate Interval Between Onset and Death<br>5 Days                                                                                                                                                   |
|                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Lung Carcinoma</u><br><u>Prostate Carcinoma</u>                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                             |                                                                                                                                                                                                   |                                         |                                                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No N/A                                                                                                                                                         |                                                                                                                                             |                                                                                                                                                                                                   |                                         |                                                                                      |                                                                                                                                                                                                          |
|                                               | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                             |                                                                                                                                                                                                   |                                         |                                                                                      |                                                                                                                                                                                                          |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                          |                                                                            | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                                                                                                             | 28b. Time of Injury<br>M                                                                                                                                                                          |                                         | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                                                                                                                          |
|                                               | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                                                                             | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                      |                                         |                                                                                      |                                                                                                                                                                                                          |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                             |                                                                                                                                                                                                   |                                         |                                                                                      |                                                                                                                                                                                                          |
|                                               | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | 29c. License number<br>D45660                                                                                                                                                                                                                                                                           |                                                                                                                                             | 29d. Date signed (Month, Day, Year)<br>6-21-00                                                                                                                                                    |                                         |                                                                                      |                                                                                                                                                                                                          |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>D. Singh, M.D.<br>14300, CALLANT FOX LN, #24, Bowie MD 20716                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                             |                                                                                                                                                                                                   |                                         |                                                                                      |                                                                                                                                                                                                          |
|                                               | 31. Date filed (Month, Day, Year)<br>JUN 27 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                                                                                                             |                                                                                                                                                                                                   |                                         |                                                                                      |                                                                                                                                                                                                          |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 22278

Baltimore, Maryland 21215-0020  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |                                                                                                                                                                                                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Clarence L. Pinkney</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 2. Date of Death<br>Month Day Year<br><b>June 21 2000</b>                                                                                                                                                                                                                                   |  | 3. Time of Death<br><b>09:12 A.M.</b>                                                                                                             |                                                                                                                                                                                                  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>                                                                                                                                                                                                                                     |  | 4c. County of Death<br><b>Prince George's</b>                                                                                                     |                                                                                                                                                                                                  |
| 5. Social Security Number<br><b>220-62-6224</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs.                                                                                                  |                                                                                                                                                                                                  |
| 8. Date of Birth (Month, Day, Year)<br><b>Sept 11, 1952</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                 |  |                                                                                                                                                   |                                                                                                                                                                                                  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |                                                                                                                                                                                                  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10b. County<br><b>Prince George's</b>                                                                                                                                                                                                                                                       |  | 10c. City, Town or Location<br><b>Landover</b>                                                                                                    |                                                                                                                                                                                                  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10e. Street and Number<br><b>1101 Nalley Rd #1028</b>                                                                                                                                                                                                                                       |  | 10f. Zip Code<br><b>20785</b>                                                                                                                     |                                                                                                                                                                                                  |
| 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                              |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                     |  |                                                                                                                                                   |                                                                                                                                                                                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Technician</b>                                                                                                                                                              |  | 16b. Kind of Business/Industry<br><b>Private</b>                                                                                                  |                                                                                                                                                                                                  |
| 17. Father's Name (First, Middle, Last)<br><b>Alfred Pinkney</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Henson</b>                                                                                                                                                                                                                     |  |                                                                                                                                                   |                                                                                                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Yvonne Pinkney-Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6209 Baltic Street Seat Pleasant MD 20743</b>                                                                                                                                           |  |                                                                                                                                                   |                                                                                                                                                                                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veterans Cemetery</b>                                                                                                                                                                                 |  | 20c. Location - City or Town, State<br><b>Cheltenham, MD</b>                                                                                      |                                                                                                                                                                                                  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 22. Name and Address of Facility<br><b>J.B. Jenkins Funeral Home<br/>7474 Landover Rd Landover MD 20785</b>                                                                                                                                                                                 |  |                                                                                                                                                   |                                                                                                                                                                                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   | Approximate Interval Between Onset and Death                                                                                                                                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                               |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                   |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                            |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b>                                                                                                                                                                                                                                           |  | 28b. Time of Injury<br><b>1</b> Yes <input type="checkbox"/> No                                                                                   |                                                                                                                                                                                                  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                      |  | 29d. Date signed (Month, Day, Year)<br><b>June 22, 2000</b>                                                                                       |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOSEPH PESTANER, M.D. 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 27 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 32. Registrar's Signature<br>                                                                                                                                                                            |  |                                                                                                                                                   |                                                                                                                                                                                                  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22279

amend item 18 per fh G786 8/2/00 yg

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0028.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                             |                                                          |                                                                                                                                                                                              |                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Charles Severn Pindell III</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | 2. Date of Death<br>Month Day Year<br><b>June 13 00</b>                                                                                                                                                                                                                                     |                                                          | 3. Time of Death<br><b>10:25 PM</b>                                                                                                                                                          |                                                                                                                                                                                                  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Union Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Baltimore</b> |                                                                                                                                                                                              | 4c. County of Death<br><b>N/A</b>                                                                                                                                                                |
| 5. Social Security Number<br><b>214-40-7854</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.                                                                                                                                                                                                                                            | If Under 1 Year<br>Months Days                           | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br><b>Mar 25, 1942</b>                                                                                                                                       |
| 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>Maryland</b>                            |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 10b. County<br><b>Baltimore City</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                                                                                                             |                                                          | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                               |                                                                                                                                                                                                  |
| 10e. Street and Number<br><b>838 Jack St.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | 10f. Zip Code<br><b>21225</b>                                                                                                                                                                                                                                                               |                                                          | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                  |                                                                                                                                                                                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                 |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>0</b>                                                                                                                                                    |                                                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Delivery Driver</b>                                                          |                                                                                                                                                                                                  |
| 16b. Kind of Business/Industry<br><b>Express Service</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | 17. Father's Name (First, Middle, Last)<br><b>Charles S. Pindell, Jr.</b>                                                                                                                                                                                                                   |                                                          | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Angela unknown</b>                                                                                                                   |                                                                                                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Angela D. Pindell - Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1664 Deer Park Rd. Finksburg, MD 21048</b>                                                                                                                                              |                                                          |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                          |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Carroll Cremation Inc</b>                                                                                                                                                                                      |                                                          | 20c. Location - City or Town, State<br><b>6-17 Hampstead, MD</b>                                                                                                                             |                                                                                                                                                                                                  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                |                                                                            | 22. Name and Address of Facility<br><b>Pritts Funeral Home and Chapel, P.A.<br/>412 Washington Rd. Westminster, MD 21157</b>                                                                                                                                                                |                                                          |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial infarction</b><br>Due to (or as a consequence of):<br><b>b. Coronary artery disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |                                                                            |                                                                                                                                                                                                                                                                                             |                                                          |                                                                                                                                                                                              | Approximate Interval Between Onset and Death<br><b>30 minutes</b><br><b>10 years</b>                                                                                                             |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>peripheral vascular disease</b>                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                          |                                                                                                                                                                                              | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                             |                                                          |                                                                                                                                                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                          |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                     |                                                                            | 28a. Date of injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                          | 28b. Time of injury<br><b>M</b>                                                                                                                                                              |                                                                                                                                                                                                  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                          | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                      |                                                                            |                                                                                                                                                                                                                                                                                             |                                                          |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 29c. License number<br><b>AT 2438946 G21</b>                                                                                                                                                                                                                                                |                                                          | 29d. Date signed (Month, Day, Year)<br><b>June 13, 00</b>                                                                                                                                    |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Firas Khowry the Union Memorial Hospital 201 E Univ pkw Baltimore MD 21208</b>                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                                                                                                                             |                                                          |                                                                                                                                                                                              |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 19 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                           |                                                          |                                                                                                                                                                                              |                                                                                                                                                                                                  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22280

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille Ann PALMER

2. Date of Death

June 30, 2000

3. Time of Death

1205 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Avalon Manor Health Care Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

5. Social Security Number

219-44-2893

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

March 2, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

123 Plantation Drive

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing Manufacturer

17. Father's Name (First, Middle, Last)

Custantino Brown

18. Mother's Name (First, Middle, Maiden Surname)

Essie Huff

19a. Informant's Name/Relationship (Type, Print)

Donald Shumaker -Son-In-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

101 Kerns Drive Boonsboro, Maryland 21713

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenlawn Memorial Park 7/3/00

Date

20c. Location - City or Town, State

Williamsport, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Minnich Funeral Home

415 E. Wilson Blvd. Hagerstown, Md. 21740

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. End Stage Renal Disease

Due to (or as a consequence of):

m

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Diabetic Mellitus

Due to (or as a consequence of):

m

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease, Arteriosclerosis

Cardiovascular Disease, Hypertension, Chronic

obstructive Pulmonary Disease, Peripheral

Vascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

218019

29d. Date signed (Month, Day, Year)

JUNE 30, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vasant Datta 334 Mill Street, Hagerstown, MD 21740

31. Date filed (Month, Day, Year)

JUL 03 2000

32. Registrar's Signature

B. Spate

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22281  
Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                       |  |                                                                                                                                                                                                          |  |                                                                                      |  |                                                           |  |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|-----------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Hazel Marie Price                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                       |  | 2. Date of Death<br>Month: 6 Day: 30 Year: 2000                                                                                                                                                          |  |                                                                                      |  | 3. Time of Death<br>5:45 pm                               |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>Homewood Retirement Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |  | 4b. City, Town, or Location of Death<br>Williamsport                                                                                                                                                     |  |                                                                                      |  | 4c. County of Death<br>Washington                         |  |
| Funeral<br>Director                           | 5. Social Security Number<br>233-34-3530                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br>74 Yrs.                                                                                                                                                                |  | 8. Date of Birth (Month, Day, Year)<br>April 20, 1926                                |  | 9. Birthplace (State or Foreign Country)<br>West Virginia |  |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       |  | 10a. State<br>Maryland                                                                                                                                                                                   |  | 10b. County<br>Washington                                                            |  | 10c. City, Town or Location<br>Williamsport               |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br>16613 Tammany Manor Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                       |  | 10f. Zip Code<br>21795                                                                                                                                                                                   |  | 10g. Citizen of What Country?<br>U.S.A.                                              |  |                                                           |  |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                     |  |                                                           |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 0-12 College (1-4 or 5+): 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Certified Professional Secretary                                                            |  |                                                                                      |  | 16b. Kind of Business/Industry<br>U.S. Government         |  |
|                                               | 17. Father's Name (First, Middle, Last)<br>Edward S. Wood                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Virginia K. Dearing                                                                                                                                   |  |                                                                                      |  |                                                           |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Rev. Dr. Norman G. Price/husband                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>16613 Tammany Manor Road, Williamsport, Maryland 21795                                                  |  |                                                                                      |  |                                                           |  |
|                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                               |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rosedale Cemetery                                                           |  | Data<br>July 3, 2000                                                                                                                                                                                     |  | 20c. Location - City or Town, State<br>Martinsburg, Virginia West                    |  |                                                           |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>Scott M. Minnich</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |  | 22. Name and Address of Facility<br>Minnich Funeral Home<br>415 East Wilson Blvd., Hagerstown, Maryland 21740                                                                                            |  |                                                                                      |  |                                                           |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Respiratory Failure<br>Due to (or as a consequence of):<br><br>Pneumonia<br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Dementia, Chronic<br>Hypertension |  |                                                                                                                                                       |  | Approximate Interval Between Onset and Death<br>~10 days                                                                                                                                                 |  |                                                                                      |  |                                                           |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>Dementia, Chronic<br>Hypertension                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                       |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |                                                                                      |  |                                                           |  |
|                                               | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |  |                                                                                      |  |                                                           |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                                |  | 28. Place of Death (Check only one)<br>Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                         |  |                                                                                      |  |                                                           |  |
|                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                        |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                |  | 28b. Time of Injury<br>M                                                                                                                                                                                 |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                         |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                              |  | 29b. Signature and title of certifier<br><i>R. L. Kusler MD</i>                                                                                       |  | 29c. License number<br>D0026579                                                                                                                                                                          |  | 29d. Date signed (Month, Day, Year)<br>7/1/00                                        |  |                                                           |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>R. L. Kusler, MD, 747 Northern Ave. Hagerstown, MD 21742                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |  |                                                                                                                                                                                                          |  |                                                                                      |  |                                                           |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>JUL 03 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |  | 32. Registrar's Signature<br><i>B. Sparks</i>                                                                                                                                                            |  |                                                                                      |  |                                                           |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22282

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                    |                                                                                             |                                                      |                                                                                                                                                                                                  |                                                          |                                                       |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1. Decedent's Name (First, Middle, Last)<br>Thomas Leroy Pompell                      |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               | 2. Date of Death<br>Month: July Day: 1 Year: 2000  |                                                                                             |                                                      |                                                                                                                                                                                                  | 3. Time of Death<br>7:30 a.m.                            |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 4a. Facility Name (If not institution, give street and number)<br>12313 Learning Lane |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               | 4b. City, Town, or Location of Death<br>Hagerstown |                                                                                             |                                                      |                                                                                                                                                                                                  | 4c. County of Death<br>Washington                        |                                                       |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 5. Social Security Number<br>213-42-646                                               |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                               | 7. Age (In yrs. last birthday)<br>56 Yrs.          |                                                                                             | 8. Date of Birth (Month, Day, Year)<br>Feb. 14, 1943 |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Usual Residence of Decedent                                                           |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                    |                                                                                             |                                                      |                                                                                                                                                                                                  |                                                          |                                                       |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       | 10b. County<br>Washington                                                                                                                                                                                                                                                                   |                                                                            | 10c. City, Town or Location<br>Hagerstown                                                                                                                                                     |                                                    |                                                                                             |                                                      | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |                                                          |                                                       |  |
| 10e. Street and Number<br>12313 Learning Lane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            | 10f. Zip Code<br>21740                                                                                                                                                                        |                                                    |                                                                                             |                                                      | 10g. Citizen of What Country?<br>U. S. A.                                                                                                                                                        |                                                          |                                                       |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                    |                                                                                             |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                 |                                                          |                                                       |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 10 College (1-4 or 5+): 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Carpet Mechanic                                                                  |                                                    |                                                                                             |                                                      | 16b. Kind of Business/Industry<br>Self employed<br>Private Business                                                                                                                              |                                                          |                                                       |  |
| 17. Father's Name (First, Middle, Last)<br>Charles Pompell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br>Rosalie Welty                                                                                                                            |                                                    |                                                                                             |                                                      |                                                                                                                                                                                                  |                                                          |                                                       |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Donna L. Pompell / spouse                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12313 Learning Lane Hagerstown, MD 21740                                                     |                                                    |                                                                                             |                                                      |                                                                                                                                                                                                  |                                                          |                                                       |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery                                                                                                                                                                                               |                                                                            | Date<br>1/5/00                                                                                                                                                                                |                                                    | 20c. Location - City or Town, State<br>Hagerstown, MD                                       |                                                      |                                                                                                                                                                                                  |                                                          |                                                       |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br>Rest Haven Funeral Chapel<br>1601 Pennsylvania Ave. Hagerstown, MD 21742                                                                                  |                                                    |                                                                                             |                                                      |                                                                                                                                                                                                  |                                                          |                                                       |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Chronic Obstructive Pulmonary Disease<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                    |                                                                                             |                                                      |                                                                                                                                                                                                  |                                                          | Approximate Interval Between Onset and Death<br>years |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Obstructive Sleep apnea<br>Obesity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                    |                                                                                             |                                                      | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                          |                                                       |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                       | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                                            |                                                                                                                                                                                               |                                                    |                                                                                             |                                                      |                                                                                                                                                                                                  |                                                          |                                                       |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                       | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                               |                                                    |                                                                                             |                                                      |                                                                                                                                                                                                  |                                                          |                                                       |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                               |                                                                                       | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                            | 28b. Time of Injury<br>M                                                                                                                                                                      |                                                    | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                      | 28d. Describe how injury occurred                                                                                                                                                                |                                                          |                                                       |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                   |                                                                                       | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                   |                                                                            | 29c. License number<br>D41786                                                                                                                                                                 |                                                    | 29d. Date signed (Month, Day, Year)<br>7/5/00                                               |                                                      |                                                                                                                                                                                                  |                                                          |                                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>J. Alencastre MD, 12821 oak hill ave, Hagerstown MD 21742                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                               |                                                    |                                                                                             |                                                      |                                                                                                                                                                                                  |                                                          |                                                       |  |
| 31. Date filed (Month, Day, Year)<br>JUL 05 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                               |                                                    |                                                                                             |                                                      |                                                                                                                                                                                                  |                                                          |                                                       |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22283

## Certificate of Death

Reg. No.

|                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                   |                                                                                                                   |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                                                                                                    |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br><b>Alice M. Papazian</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                   |                                                                                                                   | 2. Date of Death<br>Month Day Year<br><b>July 5, 2000</b>                                                                                                                                    |                                                                                                | 3. Time of Death<br><b>5:30 A.M.</b>                                                        |                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                   | 4a. Facility Name (If not institution, give street and number)<br><b>20731 El Rancho Rd.</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                   |                                                                                                                   | 4b. City, Town, or Location of Death<br><b>Boonsboro</b>                                                                                                                                     |                                                                                                | 4c. County of Death<br><b>Washington</b>                                                    |                                                                                                                                                                                                                                                                                                                    |
| Funeral<br>Director                                                                                                                                               | 5. Social Security Number<br><b>116-38-6522</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.                                                                                                  | If Under 1 Year<br>Months Days                                                                                    | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br><b>July 9, 1926</b>                                     |                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>Belgium</b>                                                                                                                                                                                                                                                         |
|                                                                                                                                                                   | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                   |                                                                                                                   |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                                                                                                    |
| To Be Completed by Funeral Director                                                                                                                               | 10a. State<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 10b. County<br><b>Prince George's</b>                                      | 10c. City, Town or Location<br><b>College Park</b>                                                                                                |                                                                                                                   |                                                                                                                                                                                              | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                             |                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                   | 10e. Street and Number<br><b>6200 Westchester Park Dr. Apt. 917</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                   | 10f. Zip Code<br><b>20740</b>                                                                                     |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>U.S.A</b>                                                  |                                                                                             |                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                              |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |                                                                                                                   | 16b. Kind of Business/Industry<br><b>Home</b>                                                                                                                                                |                                                                                                |                                                                                             |                                                                                                                                                                                                                                                                                                                    |
| To Be Completed by Physician/Medical Examiner                                                                                                                     | 17. Father's Name (First, Middle, Last)<br><b>Armenag Hovaghimian</b>                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                                                   |                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Archelous Tcherkezian</b>                                                                                                            |                                                                                                |                                                                                             |                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Artin H. Papazian (Husband)</b>                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                   |                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20740</b><br><b>6200 Westchester Park Dr. Apt. 917 College Park, Md.</b>                    |                                                                                                |                                                                                             |                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                       |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>                                             |                                                                                                                   | Date<br><b>July 6, 2000</b>                                                                                                                                                                  |                                                                                                | 20c. Location - City or Town, State<br><b>Smithsburg, Md.</b>                               |                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                   | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783</b>                                           |                                                                                                                   |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                                                                                                    |
| Physician<br>/Medical<br>Examiner                                                                                                                                 | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic breast cancer</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |                                                                            |                                                                                                                                                   |                                                                                                                   |                                                                                                                                                                                              |                                                                                                |                                                                                             | Approximate Interval Between Onset and Death<br><b>1 year</b>                                                                                                                                                                                                                                                      |
|                                                                                                                                                                   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                   |                                                                                                                   |                                                                                                                                                                                              |                                                                                                |                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                   |
|                                                                                                                                                                   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                                                                                                                                                   |                                                                                                                   |                                                                                                                                                                                              |                                                                                                |                                                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                 |
|                                                                                                                                                                   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                   |                                                                                                                   |                                                                                                                                                                                              |                                                                                                |                                                                                             | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>daughters' home</b> |
| State<br>Registrar                                                                                                                                                | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                               |                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                            |                                                                                                                   | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |                                                                                                                   |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                   |                                                                            |                                                                                                                                                   |                                                                                                                   |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                   | 29b. Signature and title of certifier<br><b>Michael J. McCormack M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                   |                                                                                                                   | 29c. License number<br><b>D 41667</b>                                                                                                                                                        |                                                                                                | 29d. Date signed (Month, Day, Year)<br><b>7.5.00</b>                                        |                                                                                                                                                                                                                                                                                                                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael J. McCormack 11110 Medical Campus Rd. Hagerstown, MD 21742</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                   |                                                                                                                   |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                                                                                                    |
| 31. Date filed (Month, Day, Year)<br><b>JUL 05 2000</b>                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                   | 32. Registrar's Signature<br> |                                                                                                                                                                                              |                                                                                                |                                                                                             |                                                                                                                                                                                                                                                                                                                    |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



10-15-12

Washington

Washington

Washington

May 9

Washington

Washington

Washington

Washington

Washington

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22284

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Michael Alton Putman

2. Date of Death

June 27 2006

3. Time of Death

9:51 AM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

213-76-5074

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Aug. 21, 1950

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2202 Waller House Court

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Plumber

16b. Kind of Business/Industry

Plumbing &amp; Heating

17. Father's Name (First, Middle, Last)

Alton Roy Putman

18. Mother's Name (First, Middle, Maiden Summa)

June Snyder

19a. Informant's Name/Relationship (Type, Print)

Diana Putman (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2202 Waller House Court, Frederick, MD 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery

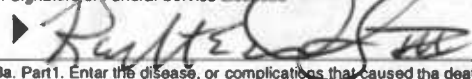
Date

6/30/00

20c. Location - City or Town, State

Frederick, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

ROBERT E. DAILEY &amp; SON FUNERAL HOMES, P.A.

1201 NORTH MARKET ST., FREDERICK, MD 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

CARDIAC ARREST

Due to (or as a consequence of):

b.

ARTERIOSCLEROTIC CARDIOVASCULAR

Due to (or as a consequence of):

c.

DISEASE

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

immediate

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

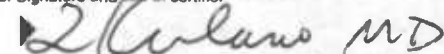
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D0022037

29d. Date signed (Month, Day, Year)

June 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L KIKLAND

6610 NINTH AVE

BRUNSWICK, MD

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-342-0020.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22285

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                     |                                                                                                                                                                                                          |                                                      |                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br>Millard Carroll Plowman, Jr.               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  | 2. Date of Death<br>Month Day Year<br>June 25, 2000 |                                                                                                                                                                                                          | 3. Time of Death<br>6:30 PM                          |                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br>5826 Shookstown Road |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br>Frederick   |                                                                                                                                                                                                          | 4c. County of Death<br>Frederick                     |                                         |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br>215-20-9374                                               |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br>74 Yrs.           |                                                                                                                                                                                                          | 8. Date of Birth (Month, Day, Year)<br>Dec. 15, 1925 |                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Maryland                                   |                                                                                                                                                                                                                                                                                                         | 10a. State<br>Maryland                                                         |                                                                                                                                                                                                  | 10b. County<br>Frederick                            |                                                                                                                                                                                                          | 10c. City, Town or Location<br>Frederick             |                                         |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                      |                                                                                | 10e. Street and Number<br>5826 Shookstown Road                                                                                                                                                   |                                                     | 10f. Zip Code<br>21702                                                                                                                                                                                   |                                                      | 10g. Citizen of What Country?<br>U.S.A. |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1944-1946                                                                                                                                                    |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |                                                      |                                         |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Self Employed/Mechanic                                                                                                                                                                     |                                                                                | 16b. Kind of Business/Industry<br>Farmers Supply                                                                                                                                                 |                                                     |                                                                                                                                                                                                          |                                                      |                                         |  |
| 17. Father's Name (First, Middle, Last)<br>Millard Carroll Plowman, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Eulah Susannah Harris                                                                                                                       |                                                     |                                                                                                                                                                                                          |                                                      |                                         |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Carroll Plowman, Son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5826 Shookstown Rd., Frederick, Md. 21702                                                       |                                                     |                                                                                                                                                                                                          |                                                      |                                         |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Faith United Church Cemetery, June 30, 2000                                                                                                                                                                                   |                                                                                | 20c. Location - City or Town, State<br>Charlesville, Md.                                                                                                                                         |                                                     |                                                                                                                                                                                                          |                                                      |                                         |  |
| 21. Signature of Funeral Service Licensee<br>R. E. Huff                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                        | 22. Name and Address of Facility<br>MO0255 Keeney and Basford P.A. Funeral Home<br>106 East Church St., Frederick, Md. 21701                                                                                                                                                                            |                                                                                |                                                                                                                                                                                                  |                                                     |                                                                                                                                                                                                          |                                                      |                                         |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. CORONARY ARTERY DISEASE<br>Due to (or as a consequence of):<br>b. ATHEROSCLEROSIS<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |                                                                                        | Approximate Interval Between Onset and Death<br>Several yrs.<br>Several yrs.                                                                                                                                                                                                                            |                                                                                |                                                                                                                                                                                                  |                                                     |                                                                                                                                                                                                          |                                                      |                                         |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>HYPERTENSION ATRIAL FIBRILLATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                     | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                      |                                         |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                        | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |                                                                                |                                                                                                                                                                                                  |                                                     |                                                                                                                                                                                                          |                                                      |                                         |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                        | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                |                                                                                                                                                                                                  |                                                     |                                                                                                                                                                                                          |                                                      |                                         |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                             |                                                                                        | 28a. Date of Injury (Month, Day, Year)<br>NA                                                                                                                                                                                                                                                            |                                                                                | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                                                      | 28d. Describe how injury occurred       |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                   |                                                                                        | 29b. Signature and title of certifier<br>MD                                                                                                                                                                                                                                                             |                                                                                | 29c. License number<br>D 0018063                                                                                                                                                                 |                                                     | 29d. Date signed (Month, Day, Year)<br>June 26, 2000                                                                                                                                                     |                                                      |                                         |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>801 TOLL HOUSE AVE FREDERICK MD 21701                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        | 31. Date filed (Month, Day, Year)<br>JUN 28 2000                                                                                                                                                                                                                                                        |                                                                                | 32. Registrar's Signature<br>B. Sparks                                                                                                                                                           |                                                     |                                                                                                                                                                                                          |                                                      |                                         |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22286

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               |                                                                                                                                                                             |                                                                                |                                                                                                                                                                                                   |                                                     |                                                                                      |                                                     |                                         |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br>Kenneth Mark Poling                               |                                                                                                                                                                             |                                                                                |                                                                                                                                                                                                   | 2. Date of Death<br>Month Day Year<br>June 23, 2000 |                                                                                      | 3. Time of Death<br>3:50 pm                         |                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br>Frederick Memorial Hospital |                                                                                                                                                                             |                                                                                |                                                                                                                                                                                                   | 4b. City, Town, or Location of Death<br>Frederick   |                                                                                      | 4c. County of Death<br>Frederick                    |                                         |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br>235-38-3185                                                      |                                                                                                                                                                             | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |                                                                                                                                                                                                   | 7. Age (In yrs. last birthday)<br>72 Yrs.           |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>June 3, 1928 |                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br>West Virginia                                     |                                                                                                                                                                             | 10a. State<br>Maryland                                                         |                                                                                                                                                                                                   | 10b. County<br>Frederick                            |                                                                                      | 10c. City, Town or Location<br>Frederick            |                                         |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                          |                                                                                | 10e. Street and Number<br>4882 Blue Spruce Lane                                                                                                                                                   |                                                     | 10f. Zip Code<br>21703                                                               |                                                     | 10g. Citizen of What Country?<br>U.S.A. |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                             |                                                                                               | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates<br>Feb 1952 - Feb 1954 |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |                                                     |                                         |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8th                                                                                                                                                                                                                                                                                                                                              |                                                                                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Excavator                                                      |                                                                                | 16b. Kind of Business/Industry<br>Excavating and Paving Company                                                                                                                                   |                                                     |                                                                                      |                                                     |                                         |  |
| 17. Father's Name (First, Middle, Last)<br>Lonnie L. Poling                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               |                                                                                                                                                                             |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ethel R. Shahan                                                                                                                              |                                                     |                                                                                      |                                                     |                                         |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Rhea Metzger Poling/Wife                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                                                                                                                                                                             |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4882 Blue Spruce Lane, Frederick, Maryland 21703                                                 |                                                     |                                                                                      |                                                     |                                         |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                    |                                                                                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Marks Lutheran Church Cemetery                                                                |                                                                                | Date<br>June 28, 2000                                                                                                                                                                             |                                                     | 20c. Location - City or Town, State<br>Wolfsville, Md.                               |                                                     |                                         |  |
| 21. Signature of Funeral Service Licensee<br>Richard C. P. Basford MD00021                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                                                                                                                                                                             |                                                                                | 22. Name and Address of Facility<br>Keeney and Basford Funeral Home<br>106 East Church Street, Frederick, Md. 21701                                                                               |                                                     |                                                                                      |                                                     |                                         |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |                                                                                               | a. <u>SEPSIS</u><br>Due to (or as a consequence of):                                                                                                                        |                                                                                | b.<br>Due to (or as a consequence of):                                                                                                                                                            |                                                     | c.<br>Due to (or as a consequence of):                                               |                                                     | d.<br>Due to (or as a consequence of):  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                                           |                                                                                               | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                   |                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                            |                                                     | Approximate Interval Between Onset and Death<br>10 days                              |                                                     |                                         |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>END STAGE RENAL DISEASE</u><br><u>DEMENTIA</u>                                                                                                                                                                                                                                                                        |                                                                                               |                                                                                                                                                                             |                                                                                |                                                                                                                                                                                                   |                                                     |                                                                                      |                                                     |                                         |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                              |                                                                                               | Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                                           |                                                                                | 26. Place of Death (Check only one)<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                             |                                                     |                                                                                      |                                                     |                                         |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                             |                                                                                               | 28a. Date of Injury (Month, Day, Year)                                                                                                                                      |                                                                                | 28b. Time of Injury<br>M                                                                                                                                                                          |                                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                     | 28d. Describe how injury occurred       |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                             |                                                                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                |                                                                                |                                                                                                                                                                                                   |                                                     |                                                                                      |                                                     |                                         |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                   |                                                                                               | 29b. Signature and title of certifier<br>[Signature] MD                                                                                                                     |                                                                                | 29c. License number<br>D29591                                                                                                                                                                     |                                                     | 29d. Date signed (Month, Day, Year)<br>June 24, 2000                                 |                                                     |                                         |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>201 Thomas Johnson Drive Frederick MD 21702                                                                                                                                                                                                                                                                                                                |                                                                                               | 31. Date filed (Month, Day, Year)<br>JUN 27 2000                                                                                                                            |                                                                                | 32. Registrar's Signature<br>[Signature]                                                                                                                                                          |                                                     |                                                                                      |                                                     |                                         |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22287

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerFuneral  
Director

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |                                                                         |                                                                                                |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>JOHANNA DOROTHEA PORRO</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 2. Date of Death<br>Month Day Year<br><b>JULY 2, 2000</b>                      |                                                                         | 3. Time of Death<br><b>7:20 PM</b>                                                             |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Charles County Nursing &amp; Rehab. Center</b>                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4b. City, Town, or Location of Death<br><b>LaPlata</b>                         |                                                                         | 4c. County of Death<br><b>Charles</b>                                                          |  |
| 5. Social Security Number<br><b>579-90-2835</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.                                                                                                                                                                                                                                                                                                                                                                             |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 10, 1921</b>                    |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>                                     |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |                                                                         |                                                                                                |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. County<br><b>Charles</b>                                                                                                                     |  | 10c. City, Town or Location<br><b>Waldorf</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |                                                                         | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><b>2504 Gittings Court</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |  | 10f. Zip Code<br><b>20602</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                 |                                                                         |                                                                                                |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                 |  |                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                                                                                                                                                                                                                                                                                |  |                                                                                | 16b. Kind of Business/Industry<br><b>Own Home</b>                       |                                                                                                |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ernest Windeler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Meta (Unavailable)</b> |                                                                         |                                                                                                |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael Porro/Son</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2504 Gittings Court, Waldorf, Maryland 20602</b>                                                                                                                                                                                                                                                                         |  |                                                                                |                                                                         |                                                                                                |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cem. 07-11-2000 Arlington, Virginia</b>                                                                                                                                                                                                                                                                                      |  |                                                                                | 20c. Location - City or Town, State                                     |                                                                                                |  |
| 21. Signature of Funeral Service Licensee<br><b>JOHN P. KNISLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |  | 22. Name and Address of Facility<br><b>The Hunt Funeral Home, Inc.<br/>P.O. Box 156, Waldorf, Maryland 20604</b>                                                                                                                                                                                                                                                                                                             |  |                                                                                |                                                                         |                                                                                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>PNEUMONIA</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |                                                                         |                                                                                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |                                                                         |                                                                                                |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |                                                                         |                                                                                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |                                                                         |                                                                                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENCIA</b><br><b>WALDENSTROM'S MACROGLOBULINEMIA</b>                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |                                                                         |                                                                                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                  |  |                                                                                |                                                                         |                                                                                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                          |  |                                                                                                                                                   |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                                                                                                                                        |  | 28b. Time of Injury<br><b>M</b>                                                |                                                                         | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
| 28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |                                                                         |                                                                                                |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                |                                                                         |                                                                                                |  |
| 29b. Signature and title of certifier<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                   |  | 29c. License number<br><b>D53385</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 29d. Date signed (Month, Day, Year)<br><b>7/5/00</b>                           |                                                                         |                                                                                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>VENKAT S. RAMANAN, MD, 6 Post Office Road #101, Waldorf, Maryland 20602</b>                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                |                                                                         |                                                                                                |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 05 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |  | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                |                                                                         |                                                                                                |  |



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State of Maryland / Department of Health and Mental Hygiene

00 22288

## Certificate of Death

Reg. No.

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------|----------------------------------|-----------------------------------|----------------------------------|--|--------------------------------|--|--|----------------------------------|--|--|----|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>HARRY (NMI) PAVEK</b>                                 |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    | 2. Date of Death<br>Month Day Year<br><b>June 27, 2000</b>              |                                                                                                | 3. Time of Death<br><b>3:50pm</b>                           |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>St. Catherines Nursing Home</b> |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    | 4b. City, Town, or Location of Death<br><b>Emmitsburg</b>               |                                                                                                | 4c. County of Death<br><b>Frederick</b>                     |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>355-03-7472</b>                                                      |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                            |                                                                                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.                                                                                                   |                                                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 18, 1918</b>             |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b> |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                          |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                      | 10b. County<br><b>Frederick</b>                                                                                                                                                                                                                                                             |                                                                                                       | 10c. City, Town or Location<br><b>Thurmont</b>                                                                                                                                                |                                                                                                                                                    |                                                                                                                                                    |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 10e. Street and Number<br><b>125 Cody Dr. Apt. #22</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                       | 10f. Zip Code<br><b>21788</b>                                                                                                                                                                 |                                                                                                                                                    | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                        |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b>                                                                                                                              |                                                                                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                    |                                                                                                                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner Operator</b>                                                            |                                                                                                                                                    |                                                                                                                                                    | 16b. Kind of Business/Industry<br><b>Metal Fabrication Co.</b>          |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 17. Father's Name (First, Middle, Last)<br><b>Frank Pavek</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Francis Cupstein</b>                                                                       |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary E. Pavek (Wife)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>125 Cody Dr., Apt. #22, Thurmont, MD 21788</b> |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                      |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b> |                                                                                                                                                                                               |                                                                                                                                                    | 20c. Date<br><b>6/28/00</b>                                                                                                                        |                                                                         | 20d. Location - City or Town, State<br><b>Smithsburg, Maryland</b>                             |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    | 22. Name and Address of Facility<br><b>Robert E. Dailey &amp; Son Funeral Homes, P.A.<br/>615 E. Main St., Thurmont, MD 21788</b>                  |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <b>congestive heart failure</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <b>2 day S</b><br/><br/> <b>1 yr.</b><br/><br/> <b>20 yrs.</b> </td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>End stage Renal Disease</b></td> </tr> <tr> <td>Due to (or as a consequence of):</td> </tr> <tr> <td></td> <td>c. <b>Rheumatoid Arthritis</b></td> <td></td> </tr> <tr> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td></td> <td>d.</td> <td></td> </tr> </table> |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <b>congestive heart failure</b> | Approximate Interval Between Onset and Death<br><br><b>2 day S</b><br><br><b>1 yr.</b><br><br><b>20 yrs.</b> | Due to (or as a consequence of): | b. <b>End stage Renal Disease</b> | Due to (or as a consequence of): |  | c. <b>Rheumatoid Arthritis</b> |  |  | Due to (or as a consequence of): |  |  | d. |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | a. <b>congestive heart failure</b>                                                                   | Approximate Interval Between Onset and Death<br><br><b>2 day S</b><br><br><b>1 yr.</b><br><br><b>20 yrs.</b>                                                                                                                                                                                |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Due to (or as a consequence of):                                                                     |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | b. <b>End stage Renal Disease</b>                                                                    |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Due to (or as a consequence of):                                                                     |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | c. <b>Rheumatoid Arthritis</b>                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Due to (or as a consequence of):                                                                     |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | d.                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Staph infection at Renal port access</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                      | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                       | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |                                                                                                                                                    | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                        |                                                                         | 28d. Describe how Injury occurred                                                              |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                       |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 29b. Signature and title of certifier<br><b>Bonita Portier - D.O.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    | 29c. License number<br><b>1744057</b>                                                                                                              |                                                                         | 29d. Date signed (Month, Day, Year)<br><b>June 28, 2000</b>                                    |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Bonita Portier, D.O., 52 Water St., Thurmont, MD 21788</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 30 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                                                                                                                                                               |                                                                                                       |                                                                                                                                                                                               |                                                                                                                                                    |                                                                                                                                                    |                                                                         |                                                                                                |                                                             |                                                                                                                                                                                                                                   |                                    |                                                                                                              |                                  |                                   |                                  |  |                                |  |  |                                  |  |  |    |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2026.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22289

## Certificate of Death

Reg. No.

|                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                   |                                                                                      |                                                                  |                                                                                                    |  |
|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Elizabeth Robinson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                               |                                                                                                                                                                                                                                                                                                         |  | 2. Date of Death<br>Month Day Year<br>June 25, 2000                                                                                                                                               |                                                                   |                                                                                      |                                                                  | 3. Time of Death<br>4:00 A.M.                                                                      |  |
|                                                  | 4a. Facility Name (If not Institution, give street and number)<br>9218 Crandall Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               |                                                                                                                                                                                                                                                                                                         |  | 4b. City, Town, or Location of Death<br>Lanham                                                                                                                                                    |                                                                   |                                                                                      |                                                                  | 4c. County of Death<br>Prince Georges                                                              |  |
| Funeral<br>Director                              | 5. Social Security Number<br>577-42-5364                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 7. Age (In yrs. last birthday)<br>69 Yrs.                                                                                                                                                         |                                                                   | 8. Date of Birth (Month, Day, Year)<br>April 10, 1931                                |                                                                  | 9. Birthplace (State or Foreign Country)<br>New York                                               |  |
|                                                  | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                   |                                                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Funeral Director              | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                               | 10b. County<br>Prince Georges                                                                                                                                                                                                                                                                           |  | 10c. City, Town or Location<br>Lanham                                                                                                                                                             |                                                                   |                                                                                      |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|                                                  | 10e. Street and Number<br>9218 Crandall Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                               |                                                                                                                                                                                                                                                                                                         |  | 10f. Zip Code<br>20706                                                                                                                                                                            |                                                                   | 10g. Citizen of What Country?<br>U.S.A.                                              |                                                                  |                                                                                                    |  |
|                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                            |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                   |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: white |                                                                                                    |  |
|                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               |                                                                                                                                                                                                                                                                                                         |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                            |                                                                   |                                                                                      |                                                                  | 16b. Kind of Business/Industry<br>Own Home                                                         |  |
|                                                  | 17. Father's Name (First, Middle, Last)<br>unobtainable Waterstraat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>unobtainable |                                                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner    | 19a. Informant's Name/Relationship (Type, Print)<br>Brenda W. Crews-Bell / Daughter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                               |                                                                                                                                                                                                                                                                                                         |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11344 Cherry Hill Rd. #303 Beltsville, MD 20705                                                  |                                                                   |                                                                                      |                                                                  |                                                                                                    |  |
|                                                  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                   |                               |                                                                                                                                                                                                                                                                                                         |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Ft. Lincoln Cemetery                                                                                                    |                                                                   | 20c. Date<br>June 29, 2000                                                           |                                                                  | 20d. Location - City or Town, State<br>Brentwood, MD                                               |  |
|                                                  | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               |                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br>Ft. Lincoln Funeral Home<br>3401 Bladensburg Rd. Brentwood, MD 20722                                                                                          |                                                                   |                                                                                      |                                                                  |                                                                                                    |  |
|                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Pulmonary Distress<br>Due to (or as a consequence of):<br>b. Ovarian Cancer<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                   |                                                                                      |                                                                  |                                                                                                    |  |
|                                                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                   |                                                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner    | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                          |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                   |                                                                                      |                                                                  |                                                                                                    |  |
|                                                  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                               |                                                                                                                                                                                                                                                                                                         |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                       |                                                                   |                                                                                      |                                                                  |                                                                                                    |  |
|                                                  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                   |                                                                   |                                                                                      |                                                                  |                                                                                                    |  |
|                                                  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                            |                               | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. Time of Injury<br>M                                                                                                                                                                          |                                                                   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how Injury occurred                                                                  |  |
|                                                  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                               |                                                                                                                                                                                                                                                                                                         |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                      |                                                                   |                                                                                      |                                                                  |                                                                                                    |  |
| State Registrar                                  | 29a. Certifier<br>(Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                     |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                   |                                                                                      |                                                                  |                                                                                                    |  |
|                                                  | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                               |                                                                                                                                                                                                                                                                                                         |  | 29c. License number<br>D0047612                                                                                                                                                                   |                                                                   |                                                                                      |                                                                  | 29d. Date signed (Month, Day, Year)<br>June 28, 2000                                               |  |
|                                                  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Paul MacKoul, M.D. 110 Irving St. NW Washington, DC 20010                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                   |                                                                                      |                                                                  |                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br>JUN 29 2000 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 32. Registrar's Signature<br> |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |                                                                   |                                                                                      |                                                                  |                                                                                                    |  |

ORIGINAL



0005 # 8 JUL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22290

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SARAH IDA RAYNOR

2. Date of Death

Month Day Year  
JUNE 24, 2000

3. Time of Death

2:10pm

4a. Facility Name (If not institution, give street and number)

7170 DONNELL PLACE #C2

4b. City, Town, or Location of Death

FORESTVILLE

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

578-26-7535

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT 18, 1915

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

FORESTVILLE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

7170 DONNELL PLACE

10f. Zip Code

20747

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SEAMSTRESS/TAILOR

16b. Kind of Business/Industry

PRIVATE

17. Father's Name (First, Middle, Last)

NORMAN DAVIS SR

18. Mother's Name (First, Middle, Maiden Surname)

ADDIE ROUSE

19a. Informant's Name/Relationship (Type, Print)

ADDIE BEATTY / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7170 DONNELL PLACE, FORESTVILLE, MD 20747

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ARLINGTON NATIONAL CEMETERY 6-30-00 ARLINGTON, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOME

5538 MARLBORO PIKE, FORESTVILLE, MD 20747

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Arrest (cardio-  
Due to (or as a consequence of):b. Metastatic Colon CANCER  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

2 mo

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

MD 7394 (Hi)

29d. Date signed (Month, Day, Year)

JUN 26 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rickey Myland Hematology/Oncology Walter Reed AMC Washington DC

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Handwritten notes, possibly a signature or title, located in the upper middle section of the page.

X

X

X

X

X

X

Handwritten notes at the bottom of the page, including the date "10-20-60" and other illegible text.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22291

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                       |  |                                                                            |                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |  |                                                             |                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Bernadette Frances Romeo</b>                                                                                                                                                           |  |                                                                            |                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br><b>June 28, 2000</b>                                                                                                                                                                                                                                  |  |                                                             |                                                                                             | 3. Time of Death<br><b>3:45 am</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>7548 Newberry Lane</b>                                                                                                                                           |  |                                                                            |                                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>Lanham</b>                                                                                                                                                                                                                                       |  |                                                             |                                                                                             | 4c. County of Death<br><b>Prince George's</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>200-20-0461</b>                                                                                                                                                                                       |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.                                                                                                                                                                                                                                            |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 27, 1928</b> |                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                           |  |                                                                            |                                                                                                                                                                         | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                               |  | 10b. County<br><b>Prince George's</b>                       |                                                                                             | 10c. City, Town or Location<br><b>Lanham</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                         |  |                                                                            |                                                                                                                                                                         | 10b. County<br><b>Prince George's</b>                                                                                                                                                                                                                                                       |  |                                                             |                                                                                             | 10c. City, Town or Location<br><b>Lanham</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                        |  |                                                                            |                                                                                                                                                                         | 10e. Street and Number<br><b>7548 Newberry Lane</b>                                                                                                                                                                                                                                         |  |                                                             |                                                                                             | 10f. Zip Code<br><b>20706</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                                                        |  |                                                                            |                                                                                                                                                                         | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                              |  |                                                             |                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                          |  |                                                                            |                                                                                                                                                                         | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                     |  |                                                             |                                                                                             | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Office Manager</b>                                                                                                    |  |                                                                            |                                                                                                                                                                         | 16b. Kind of Business/Industry<br><b>University of Maryland</b>                                                                                                                                                                                                                             |  |                                                             |                                                                                             | 17. Father's Name (First, Middle, Last)<br><b>Lloyd R. Hucke</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Estella Hummel</b>                                                                                                                                                            |  |                                                                            |                                                                                                                                                                         | 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard J. Romeo - Son</b>                                                                                                                                                                                                           |  |                                                             |                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2434 Hyannis Lane, Crofton, MD 21114</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |                                                                            |                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>                                                                                                                                                                                    |  |                                                             |                                                                                             | 20c. Location - City or Town, State<br><b>7/1/00 Silver Spring, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br><b>Henry S. Ford</b>                                                                                                                                                                     |  |                                                                            |                                                                                                                                                                         | 22. Name and Address of Facility<br><b>Gasch's Funeral Home, P.A.<br/>4739 Baltimore Avenue Hyattsville, MD 20781</b>                                                                                                                                                                       |  |                                                             |                                                                                             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Renal Cell Carcinoma</b><br>Due to (or as a consequence of):<br><br>b. <b>Hypertension</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                      |  |                                                                            |                                                                                                                                                                         | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                       |  |                                                             |                                                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                     |  |                                                                            |                                                                                                                                                                         | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                             |                                                                                             | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                 |  |  |
| 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                       |  |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                         |                                                                                                                                                                                                                                                                                             |  |                                                             | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
| 28d. Describe how Injury occurred                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                       |  |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                  |                                                                                                                                                                                                                                                                                             |  |                                                             | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                       |  |                                                                            | 29b. Signature and title of certifier<br><b>Wilkinson J. Ninala</b>                                                                                                     |                                                                                                                                                                                                                                                                                             |  |                                                             | 29c. License number<br><b>D45 285</b>                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>June 28, 2000</b>                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                       |  |                                                                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wilkinson J. Ninala, 344 University Blvd., #113, Silver Spring, MD 20901</b> |                                                                                                                                                                                                                                                                                             |  |                                                             | 31. Date filed (Month, Day, Year)<br><b>JUN 28 2000</b>                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |
| 32. Registrar's Signature<br><b>By [Signature]</b>                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                       |  |                                                                            | 33. Registrar's Signature<br><b>[Signature]</b>                                                                                                                         |                                                                                                                                                                                                                                                                                             |  |                                                             | 34. Registrar's Signature<br><b>[Signature]</b>                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22292

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                               |                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                               |                                                                                                                                                                                                                                                                            |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Kenneth E. Raftery</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 2. Date of Death<br>Month <b>June</b> Day <b>22</b> Year <b>2000</b>                                                                                          |                                                      | 3. Time of Death<br><b>2:47 A.M.</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                               |                                                                                                                                                                                                                                                                            |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>2525 Appleton Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                               | 4b. City, Town, or Location of Death<br><b>Bowie</b> |                                                                                                                                                                                                                                                                                                                                                                                                                              | 4c. County of Death<br><b>Prince George's</b> |                                                                                                                                                                                                                                                                            |  |
| 5. Social Security Number<br><b>103 22 4374</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                    |                                                      | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.                                                                                                                                                                                                                                                                                                                                                                             |                                               | 8. Date of Birth (Month, Day, Year)<br><b>July 7 1931</b>                                                                                                                                                                                                                  |  |
| 9. Birthplace (State or Foreign Country)<br><b>New York</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 10a. State<br><b>Maryland</b>                                                                                                                                 |                                                      | 10b. County<br><b>Prince George's</b>                                                                                                                                                                                                                                                                                                                                                                                        |                                               | 10c. City, Town or Location<br><b>Bowie</b>                                                                                                                                                                                                                                |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10e. Street and Number<br><b>2525 Appleton Lane</b>                                                                                                           |                                                      | 10f. Zip Code<br><b>20716</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                               | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                                                                                                                      |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |                                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                |                                               | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Realtor</b>                                   |                                                      | 16b. Kind of Business/Industry<br><b>Real Estate</b>                                                                                                                                                                                                                                                                                                                                                                         |                                               | 17. Father's Name (First, Middle, Last)<br><b>Edward J. Raftery</b>                                                                                                                                                                                                        |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alice R. Brennan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Nancy W. Raftery Wife</b>                                                                              |                                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2525 Appleton Lane Bowie Maryland 20716</b>                                                                                                                                                                                                                                                                              |                                               | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>The Hunt Crematory</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20c. Location - City or Town, State<br><b>Waldorf Maryland</b>                                                                                                |                                                      | 21. Signature of Funeral Service Licensee<br><b>Robert E. Evans</b>                                                                                                                                                                                                                                                                                                                                                          |                                               | 22. Name and Address of Facility<br><b>Robert E. Evans Funeral Home, Inc.<br/>16000 Annapolis Rd. Bowie Maryland 20715</b>                                                                                                                                                 |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. METASTATIC Prostate Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>4 yrs</b>                                                                                                  |                                                      | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                             |                                               | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                      |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                             |                                                      | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                  |                                               | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |
| 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28b. Time of Injury<br><b>M</b>                                                                                                                               |                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                  |                                               | 28d. Describe how injury occurred                                                                                                                                                                                                                                          |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                  |                                                      | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                               | 29b. Signature and title of certifier<br><b>How Henry</b>                                                                                                                                                                                                                  |  |
| 29c. License number<br><b>D28768</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 29d. Date signed (Month, Day, Year)<br><b>6/22/2000</b>                                                                                                       |                                                      | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>1600 ORLEANS ST. BALTIMORE MD 21213 - 1000</b>                                                                                                                                                                                                                                                                                    |                                               | 31. Date filed (Month, Day, Year)<br><b>JUN 27 2000</b>                                                                                                                                                                                                                    |  |
| 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 33. State Registrar<br><b>[Signature]</b>                                                                                                                     |                                                      | 34. State Registrar<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                    |                                               | 35. State Registrar<br><b>[Signature]</b>                                                                                                                                                                                                                                  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



9825 9 2 1000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 24a per phys. G787 9/14/00 yf

## Certificate of Death

Reg. No.

00 22293

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edwards Pierce Roberson

2. Date of Death

Month Day Year  
May 30, 2000

3. Time of Death

9:37 PM

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

248-12-1961

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 21, 1917 North Carolina

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

228 Thames Drive

10f. Zip Code

21702

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

1943 to 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Distributor

16b. Kind of Business/Industry

Newspaper Distribution Agency

17. Father's Name (First, Middle, Last)

Virgel Odell Roberson

18. Mother's Name (First, Middle, Maiden Surname)

Manassas Brown

19a. Informant's Name/Relationship (Type, Print)

Mildred M. Roberson/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

228 Thames Drive, Frederick, Md. 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resthaven Memorial Gardens June 5, 2000 Frederick, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Richard C. C. Buford

M00021

22. Name and Address of Facility

Keeney &amp; Basford Funeral Home

106 East Church Street, Frederick, Md. 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. acute M.I.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. post. (L) to tel pneumonia for

Due to (or as a consequence of):

cancer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Nicholas P. Foris MD

29c. License number

D03666

29d. Date signed (Month, Day, Year)

6/1/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NICHOLAS P. FORIS M.D. 74 Thomas Towne Drive Frederick, MD 21701

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 02 2000

32. Registrar's Signature

B. A. Spahr

EDWARDS PIERCE ROBERSON

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22294

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN EVERETT RUSSELL</b>                                |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>June 26 2000</b> |                                                                                             | 3. Time of Death<br><b>9:45 PM</b>                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis ElderCare - The Pines</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Easton</b>     |                                                                                             | 4c. County of Death<br><b>Talbot</b>                        |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5. Social Security Number<br><b>214-18-4999</b>                                                        |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.          |                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 14, 1910</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                            |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>MD</b>                                                    |                                                                                                                                                                                              | 10b. County<br><b>TALBOT</b>                              |                                                                                             | 10c. City, Town or Location<br><b>EASTON</b>                |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        | 10e. Street and Number<br><b>610 DUTCHMAN'S LANE</b>                                                                                                                                                                                                                                        |                                                                            | 10f. Zip Code<br><b>21601</b>                                                                                                                                                                |                                                           | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                              |                                                             |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MAINTENANCE FOREMAN</b>                                                                                                                                                     |                                                                            | 16b. Kind of Business/Industry<br><b>BOAT MAINTENANCE</b>                                                                                                                                    |                                                           |                                                                                             |                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>JOHN RUSSELL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELMIRA ELLISON</b>                                                                                                                   |                                                           |                                                                                             |                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>PATRICIA ANN POTTER/NIECE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>104 RICHARDSON STREET, OXFORD, MD 21654</b>                                              |                                                           |                                                                                             |                                                             |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE CREMATION CENTER L.L.C.</b>                                                                                                                                                                         |                                                                            | 20c. Location - City or Town, State<br><b>CHESTER, MD</b>                                                                                                                                    |                                                           | 20d. Date<br><b>6/28/00</b>                                                                 |                                                             |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN, &amp; NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON, MD 21601</b>                                                       |                                                           |                                                                                             |                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Bilateral Pneumonia</b><br>Due to (or as a consequence of):<br><b>b. Dementia - Alzheimer's Type</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Approximate Interval Between Onset and Death<br><b>10 days</b><br><b>2 yrs</b> |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                             |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>S1ADH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                             |  |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                             |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                             |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                             |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                |                                                                                                        | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                             |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                       |                                                           |                                                                                             |                                                             |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                             |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                              |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                             |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            | 29c. License number<br><b>D 9024</b>                                                                                                                                                         |                                                           | 29d. Date signed (Month, Day, Year)<br><b>6/27/2000</b>                                     |                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBERT McDONALD, MD 30 DOVER STREET EASTON, MD 21601</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 28 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                           |                                                                                             |                                                             |  |



00 22295

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |                                                                                                                                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charlotte Virginia RIDENOUR</b>                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 2. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>28</b> YEAR <b>2000</b>                                                                                                                     |  | 3. TIME OF DEATH<br><b>11:59 AM</b>                                                                                                              |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-42-3668</b>                                                                                                                                                                                                                                                                                                                                                              |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.                                                                                                                                       |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug 24 1923</b>                                                                                        |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>617 Maryland Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>                                                                                                                               |  | 9c. COUNTY OF DEATH<br><b>Washington</b>                                                                                                         |  |
| 10a. STATE<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10b. COUNTY<br><b>Washington</b>                                                                                                                                                       |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>                                                                                                 |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10e. STREET AND NUMBER<br><b>617 Maryland Avenue</b>                                                                                                                                   |  | 10f. ZIP CODE<br><b>21740</b>                                                                                                                    |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                |  |                                                                                                                                                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0-12</b><br>College (1-4 or 5+) <b>0-2</b>                                                                                                                                                                                                                                                              |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Her own home</b>                                                                                                                                  |  |                                                                                                                                                  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Emory Gouker</b>                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ruth Hauver</b>                                                                                                                |  |                                                                                                                                                  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Carol Rowland - Daughter</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17430 Virginia Avenue Hagerstown, Md. 21740</b>                                    |  |                                                                                                                                                  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                              |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Lawn Memorial Park 7/1/00</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>                                                                                                                     |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott Minnich</i>                                                                                |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Minnich Funeral Home<br/>415 E. Wilson Blvd. Hagerstown, Maryland</b>                                                                                                                                                                                                                                                                                                 |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CEREBRAL VASCULAR DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>DEMENCIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>CEREBRAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>YEARS</b><br><b>YEARS</b><br><b>1995</b> |  |                                                                                                                                                                                        |  |                                                                                                                                                  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                        |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                            |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                        |  |                                                                                                                                                  |  |
| 28a. DATE OF INJURY (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                       |  | 28b. TIME OF INJURY<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                                                                                   |  | 28d. DESCRIBE HOW INJURY OCCURRED                                                                                                                |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                       |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                        |  |                                                                                                                                                  |  |
| 29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |                                                                                                                                                  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>D. Woods</i> MD                                                                                                                                                                                                                                                                                                                                                  |  | 29c. LICENSE NUMBER<br><b>D22043</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>6/29/00</b>                                                                                                                                  |  |                                                                                                                                                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print)<br><b>11110 MEDICAL CAMPUS RD HAGERSTOWN MD 21742</b>                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                        |  |                                                                                                                                                  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUN 30 2000</b>                                                                                                                                                                                                                                                                                                                                                      |  | 32. REGISTRAR'S SIGNATURE<br><i>B. Sparks</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                        |  |                                                                                                                                                  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22296

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                  |                                                                                                                                                        |                                                                         |                                                                                                         |                                                             |                                                               |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br><b>EDWARD LEROY REYNOLDS</b>                                       |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                  |                                                                                                                                                        | 2. Date of Death<br>Month <b>7</b> Day <b>1</b> Year <b>2000</b>        |                                                                                                         | 3. Time of Death<br><b>4:30 a.m.</b>                        |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND MEDICAL CENTER</b> |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                  |                                                                                                                                                        | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                |                                                                                                         | 4c. County of Death<br><b>Baltimore</b>                     |                                                               |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br><b>219-44-4510</b>                                                                |                                                                                                                                                                                  | 6. Sex<br><b>1</b> M <b>2</b> F |                                                                                                                                                   | 7. Age (In yrs. last birthday)<br><b>55</b> Yrs. |                                                                                                                                                        | 8. Date of Birth (Month, Day, Year)<br><b>February 18, 1945</b>         |                                                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Usual Residence of Decedent                                                                                    |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                  |                                                                                                                                                        |                                                                         |                                                                                                         |                                                             |                                                               |  |
| 10a. State<br><b>W. Va.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                | 10b. County<br><b>Berkeley</b>                                                                                                                                                   |                                 | 10c. City, Town or Location<br><b>Falling Waters</b>                                                                                              |                                                  |                                                                                                                                                        |                                                                         | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No                                                     |                                                             |                                                               |  |
| 10e. Street and Number<br><b>132 Lockhouse Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                |                                                                                                                                                                                  |                                 | 10f. Zip Code<br><b>25419</b>                                                                                                                     |                                                  | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                            |                                                                         |                                                                                                         |                                                             |                                                               |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:                                                                           |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |                                                  |                                                                                                                                                        | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                         |                                                             |                                                               |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                |                                                                                                                                                                                  |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>service technician</b>            |                                                  |                                                                                                                                                        | 16b. Kind of Business/Industry<br><b>Office Equipment</b>               |                                                                                                         |                                                             |                                                               |  |
| 17. Father's Name (First, Middle, Last)<br><b>Raymond Calvin Reynolds</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Carrie M. Keefer</b>                                                                           |                                                                         |                                                                                                         |                                                             |                                                               |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Hannah K. Reynolds Wife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>132 Lockhouse Road Falling Waters W. Va. 25419</b> |                                                                         |                                                                                                         |                                                             |                                                               |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                |                                                                                                                                                                                  |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Lawn Memorial Park</b>                                         |                                                  | Date<br><b>7/6/00</b>                                                                                                                                  |                                                                         | 20c. Location - City or Town, State<br><b>Hagerstown, Maryland</b>                                      |                                                             |                                                               |  |
| 21. Signature of Funeral Service Licensee<br><i>Gerald N. Minnich</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                |                                                                                                                                                                                  |                                 | 22. Name and Address of Facility<br><b>Gerald N. Minnich 305 N. Potomac Street<br/>Funeral Home Hagerstown, Maryland 21740</b>                    |                                                  |                                                                                                                                                        |                                                                         |                                                                                                         |                                                             |                                                               |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br><b>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b> |                                                                                                                |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                  |                                                                                                                                                        |                                                                         |                                                                                                         |                                                             | Approximate Interval Between Onset and Death<br><b>6 DAYS</b> |  |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                  | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No                                                                                             |                                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No |                                                             |                                                               |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |                                 |                                                                                                                                                   |                                                  |                                                                                                                                                        |                                                                         |                                                                                                         |                                                             |                                                               |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                | 28a. Date of Injury (Month, Day Year)                                                                                                                                            |                                 | 28b. Time of Injury<br><b>M</b>                                                                                                                   |                                                  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No                                                                                                       |                                                                         | 28d. Describe how injury occurred                                                                       |                                                             |                                                               |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                |                                                                                                                                                                                  |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |                                                  |                                                                                                                                                        |                                                                         |                                                                                                         |                                                             |                                                               |  |
| 29a. Certifier (Check only one)<br><b>2</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                  |                                                                                                                                                        |                                                                         |                                                                                                         |                                                             |                                                               |  |
| 29b. Signature and title of certifier<br><i>Thomas Maslon MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                |                                                                                                                                                                                  |                                 | 29c. License number<br><b>211771</b>                                                                                                              |                                                  | 29d. Date signed (Month, Day, Year)<br><b>7/1/2000</b>                                                                                                 |                                                                         |                                                                                                         |                                                             |                                                               |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THOMAS MASLON 22 S. GREENE ST, BALTIMORE MD 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                |                                                                                                                                                                                  |                                 |                                                                                                                                                   |                                                  |                                                                                                                                                        |                                                                         |                                                                                                         |                                                             |                                                               |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 03 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                |                                                                                                                                                                                  |                                 | 32. Registrar's Signature<br><i>Thomas Maslon</i>                                                                                                 |                                                  |                                                                                                                                                        |                                                                         |                                                                                                         |                                                             |                                                               |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22297

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY ANN RAUER

2. Date of Death

Month  
JULYDay  
03Year  
00

3. Time of Death

1:15 a.m.

4a. Facility Name (If not institution, give street and number)

Western Maryland Hospital Center

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington

Funeral  
Director

5. Social Security Number

154-10-4978

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 22, 1922

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10e. State

MD

10b. County

Washington Co.

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

13715 Dixie Drive

10f. Zip Code

21742

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Peter Leach

18. Mother's Name (First, Middle, Maiden Surname)

Catherine UNKNOWN Leach

19a. Informant's Name/Relationship (Type, Print)

Henry E. Rauer/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13715 Dixie Drive, Hagerstown, Maryland 21742

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Lawn Memorial Park

Date

July 7

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Douglas A. Fiery Funeral Home  
1331 Eastern Blvd., N., Hagerstown, Maryland 21742

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. HYPERTENSION

Due to (or as a consequence of):

b. RENAL FAILURE

Due to (or as a consequence of):

c. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

d. CARDIAC ARRHYTHMIAS

Approximate Interval Between Onset and Death

6 Hours

4 YEARS

MONTHS

MONTHS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Vascular Disease  
Pneumonia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

845031-

29d. Date signed (Month, Day, Year)

July 3rd 00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARAB 2 SLODQUI

1500 Pennsylvania Avenue

Hagerstown, MD 21742

31. Date filed (Month, Day, Year)

JUL 05 2000

32. Registrar's Signature

State  
RegistrarRAUER, Mary Ann  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0056.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



FRED  
RACHEL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22298

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                          |                                                            |                                                                                                                                                        |                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1. Decedent's Name (First, Middle, Last)<br><b>Fred S. Rachel Jr.</b>                                  |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                          | 2. Date of Death<br>Month Day Year<br><b>JUNE 30, 2000</b> |                                                                                                                                                        | 3. Time of Death<br><b>11:21A.M.</b>                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4a. Facility Name (If not institution, give street and number)<br><b>WASHINGTON ADVENTIST HOSPITAL</b> |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                          | 4b. City, Town, or Location of Death<br><b>TAKOMA PARK</b> |                                                                                                                                                        | 4c. County of Death<br><b>MONTGOMERY</b>                   |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5. Social Security Number<br><b>213-54-5641</b>                                                        |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br><b>50</b> Yrs.           |                                                                                                                                                        | 8. Date of Birth (Month, Day, Year)<br><b>July 2, 1949</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                            |                                                                                                                                                                                                                                                                                                         | 10a. State<br><b>Maryland</b>                                                  |                                                                                                                                                                                                          | 10b. County<br><b>Montgomery</b>                           |                                                                                                                                                        | 10c. City, Town or Location<br><b>Gaithersburg</b>         |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 10e. Street and Number<br><b>416 N. Summit Avenue Apt. 202</b>                                                                                                                                                                                                                                          |                                                                                | 10f. Zip Code<br><b>20877</b>                                                                                                                                                                            |                                                            | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                  |                                                            |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>Vietnam</b>                                                                                                                                    |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                |                                                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>Collage (1-4 or 5+)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Repair/ Sales</b>                                                                                                                                                                       |                                                                                | 16b. Kind of Business/Industry<br><b>Electronics</b>                                                                                                                                                     |                                                            |                                                                                                                                                        |                                                            |  |
| 17. Father's Name (First, Middle, Last)<br><b>Fred S. Rachel Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Norma Jean Riley</b>                                                                                                                             |                                                            |                                                                                                                                                        |                                                            |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Tammy Haught/ Sister</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>705 North Warfield Drive, Mt. Airy, Maryland 21771</b>                                               |                                                            |                                                                                                                                                        |                                                            |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cemetery 7/3/2000</b>                                                                                                                                                                                           |                                                                                | 20c. Location - City or Town, State<br><b>Frederick, Maryland</b>                                                                                                                                        |                                                            |                                                                                                                                                        |                                                            |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        | 22. Name and Address of Facility<br><b>Olin L. Molesworth P. A. Funeral Home</b><br><b>26401 Ridge Road, Damascus, Maryland 20872</b>                                                                                                                                                                   |                                                                                |                                                                                                                                                                                                          |                                                            |                                                                                                                                                        |                                                            |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Atherosclerotic cardiovascular disease</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____ |                                                                                                        | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                            |                                                                                |                                                                                                                                                                                                          |                                                            |                                                                                                                                                        |                                                            |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                            |                                                                                                                                                        |                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                |                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                            |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                                                                |                                                                                                                                                                                                          |                                                            |                                                                                                                                                        |                                                            |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                                                | 28b. Time of Injury<br>M                                                                                                                                                                                 |                                                            | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                   |                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                       |                                                                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                   |                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                           |                                                            |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                          |                                                                                                        | 29b. Signature and title of certifier<br>                                                                                                                                                                            |                                                                                | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                   |                                                            | 29d. Date signed (Month, Day, Year)<br><b>JULY 1, 2000</b>                                                                                             |                                                            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David R. Fowler</b><br><b>111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        | 31. Date filed (Month, Day, Year)<br><b>JUL 03 2000</b>                                                                                                                                                                                                                                                 |                                                                                | 32. Registrar's Signature<br>                                                                                        |                                                            |                                                                                                                                                        |                                                            |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22299

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                    |                                                                                                                                                                                               |                                                                                                                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM HARRISON RAMEY</b>                       |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>JUNE 30 2000</b>                                                                                          |                                                                                                                                                                                               | 3. Time of Death<br><b>7:25 pm</b>                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br><b>25131 OLD HUNDRED ROAD</b> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>DICKERSON</b>                                                                                           |                                                                                                                                                                                               | 4c. County of Death<br><b>MONTGOMERY</b>                                                                                                                                                         |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br><b>225-12-2600</b>                                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.                                                                                                   | If Under 1 Year<br>Months Days                                                                                                                                                                | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br><b>NOV 4 1922</b>                                        |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>VA</b>                                                                                              |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                    |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 | 10b. County<br><b>MONTGOMERY</b>                                                                                                                                                                                                                                                            |                                                                                                                                                    | 10c. City, Town or Location<br><b>DICKERSON</b>                                                                                                                                               |                                                                                                                                                                                                  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                    |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 10a. Street and Number<br><b>25131 OLD HUNDRED ROAD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 |                                                                                                                                                                                                                                                                                             | 10f. Zip Code<br><b>20842</b>                                                                                                                      |                                                                                                                                                                                               | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>                                                                                                                               |                                                                                                                                                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                    |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FARMER</b>                                                                                                                                                                  |                                                                                                                                                    | 16b. Kind of Business/Industry<br><b>FARMING</b>                                                                                                                                              |                                                                                                                                                                                                  |
| 17. Father's Name (First, Middle, Last)<br><b>SAMUEL RAMEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                 |                                                                                                                                                                                                                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ELIZABETH LANG</b>                                                                         |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>HAZEL SISK/NIECE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                                                                                                                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7403 BUNKER HILL RD., THE PLAINS, VA 20198</b> |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HYATTSTOWN CEMETERY</b>                                                                                                                                                                                        |                                                                                                                                                    | 20c. Location - City or Town, State<br><b>7/3 HYATTSTOWN, MD</b>                                                                                                                              |                                                                                                                                                                                                  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 | 22. Name and Address of Facility<br><b>HILTON FUNERAL HOME<br/>BOX 86, BARNESVILLE, MD 20838</b>                                                                                                                                                                                            |                                                                                                                                                    |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>LUNG CANCER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>6 weeks</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                    |                                                                                                                                                                                               | Approximate Interval Between Onset and Death                                                                                                                                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                    |                                                                                                                                                                                               | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                    |                                                                                                                                                                                               | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                    |                                                                                                                                                                                               | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                 | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                    |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 | 28a. Date of Injury (Month, Day Year)<br><b></b>                                                                                                                                                                                                                                            |                                                                                                                                                    | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                 |                                                                                                                                                    | 28d. Describe how injury occurred                                                                                                                                                             |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                 | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                  |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                          |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                    |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                 | 29c. License number<br><b>32407</b>                                                                                                                                                                                                                                                         |                                                                                                                                                    | 29d. Date signed (Month, Day, Year)<br><b>JULY 3, 2000</b>                                                                                                                                    |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOSEPH M. HAGGERTY MD 9707 MEDICAL CTR DR ROCKVILLE MD 20850</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                    |                                                                                                                                                                                               |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 03 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 | 32. Registrar's Signature<br>                                                                                                                                                                           |                                                                                                                                                    |                                                                                                                                                                                               |                                                                                                                                                                                                  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





0 2 4 6 8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22301

|                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                  |  |
|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br><b>Orlando Jerome Sullivan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |  | 2. Date of Death<br>Month Day Year<br><b>June 26 2000</b>                                                                                                                                                                                                                                                                                                                                                                 |  | 3. Time of Death<br><b>1718</b>                                                                                                                                                                  |  |
|                                                  | 4a. Facility Name (If not institution, give street and number)<br><b>4811 EMO STREET</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br><b>Capitol Heights</b>                                                                                                                                                                                                                                                                                                                                                            |  | 4c. County of Death<br><b>Prince George's</b>                                                                                                                                                    |  |
| Funeral<br>Director                              | 5. Social Security Number<br><b>409-42-7469</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.                                                                                                                                                                                                                                                                                                                                                                          |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 5, 1929</b>                                                                                                                                      |  |
|                                                  | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 10b. County<br><b>Prince George's</b>                                                                                                             |  | 10c. City, Town or Location<br><b>Capitol Heights</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |  |
| To Be Completed by<br>Funeral Director           | 10e. Street and Number<br><b>4811 EMO Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   |  | 10f. Zip Code<br><b>20743</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                                            |  |
|                                                  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                              |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                          |  |
| To Be Completed by<br>Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Custodial Engineer</b>                                                                                                                                                                                                                                                                                    |  | 16b. Kind of Business/Industry<br><b>Nursing Home</b>                                                                                                                                            |  |
|                                                  | 17. Father's Name (First, Middle, Last)<br><b>John A. Sullivan</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Willa B. Crook</b>                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                  |  |
| To Be Completed by<br>Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Carlton Sullivan / Brother</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4811 EMO Street Capitol Heights, Maryland 20743</b>                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                  |  |
|                                                  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oaklawn Cemetery</b>                                                 |  | Date<br><b>7/1/00</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20c. Location - City or Town, State<br><b>Gadsden, Alabama</b>                                                                                                                                   |  |
| To Be Completed by<br>Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><i>Keith A. Savage M1085</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  | 22. Name and Address of Facility<br><b>Alexander S. Pope Funeral Homes</b><br><b>5538 Marlboro Pike/Forestville, Md. 20747</b>                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                  |  |
|                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Arteriosclerotic Cardiovascular Disease</i><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                   |  | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
| To Be Completed by<br>Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                                  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |  |
| To Be Completed by<br>Physician/Medical Examiner | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                  |  |
|                                                  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                          |  | 28a. Date of Injury (Month, Day Year)                                                                                                             |  | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |  |
| To Be Completed by<br>Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |
|                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                                                                                                                                                                                  |  |
| To Be Completed by<br>Physician/Medical Examiner | 29b. Signature and title of certifier<br><i>Salvador Sylvester, DO</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |  | 29c. License number<br><b>110055927</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 29d. Date signed (Month, Day, Year)<br><b>June 27 2000</b>                                                                                                                                       |  |
|                                                  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Salvador Sylvester, 3001 Hospital Drive, Cheverly, Maryland 20785</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                  |  |
| State<br>Registrar                               | 31. Data filed (Month, Day, Year)<br><b>JUN 29 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |  | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                  |  |



10698 00

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22302

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Annie M. Smith

2. Date of Death

Month Day Year  
June 22, 2000

3. Time of Death

8:57am

4a. Facility Name (If not institution, give street and number)

Southern Maryland Hospital

4b. City, Town, or Location of Death

Clinton

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-14-7131

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 25, 1912 Abbeville, S.C.

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

9601 Pineview Ln.

10f. Zip Code

20735

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic Engineer

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

James Roebuck

18. Mother's Name (First, Middle, Maiden Surname)

Lula M. Robinson

19a. Informant's Name/Relationship (Type, Print)

Harold Smith / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3100 Metronome Turn Clinton, Maryland 20735

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lincoln Cemetery

Date

6/29/00

20c. Location - City or Town, State

Suitland, Md.

21. Signature of Funeral Service Licensee

Keith A. George M1085

22. Name and Address of Facility

Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Md. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intra Cerebral hemorrhage

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Rahimian MD

29c. License number

D0052999

29d. Date signed (Month, Day, Year)

6/22/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALI RAHIMIAN MD 7801 Old Branch Ave 409 Clinton MD 20735

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

B. Smith

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

5000

22



5000 5000 5000 5000 5000 5000 5000 5000 5000 5000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22303

Funeral Director

Physician  
/Medical  
Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                          |                                                                                                                                                                                                                                                                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Willie Marie Smith</b>                                                                                                                                                                                                                                                                                                                                               |  | 2. Date of Death<br>Month <b>06</b> Day <b>24</b> Year <b>2000</b>                                                                                |                                                          | 3. Time of Death<br><b>2:25pm</b>                                                                                                                                                                                                                                                                                                                                                                                            |                                          |                                                                                                                                                                                                                                                                            |  |
| 4a. Facility Name (If not Institution, give street and number)<br><b>Washington Adventist Hospital</b>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   | 4b. City, Town, or Location of Death<br><b>Takoma Pk</b> |                                                                                                                                                                                                                                                                                                                                                                                                                              | 4c. County of Death<br><b>Montgomery</b> |                                                                                                                                                                                                                                                                            |  |
| 5. Social Security Number<br><b>577-58-1492</b>                                                                                                                                                                                                                                                                                                                                                                     |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |                                                          | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.                                                                                                                                                                                                                                                                                                                                                                             |                                          | 8. Date of Birth (Month, Day, Year)<br><b>03-06-1927</b>                                                                                                                                                                                                                   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Washington DC</b>                                                                                                                                                                                                                                                                                                                                                    |  | 10a. State<br><b>MD</b>                                                                                                                           |                                                          | 10b. County<br><b>Montgomery</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                          | 10c. City, Town or Location<br><b>Burtonville</b>                                                                                                                                                                                                                          |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                      |  | 10e. Street and Number<br><b>14117 Armilla Ct</b>                                                                                                 |                                                          | 10f. Zip Code<br><b>20866</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                          | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                                                                                             |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                      |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                 |                                          | 14. Race - American Indian, Black, White, etc.<br>Specify <b>Black</b>                                                                                                                                                                                                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b><br>College (1-4 or 5+) <b>Dietician</b>                                                                                                                                                                                                                                                                  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Hospital</b>                      |                                                          | 16b. Kind of Business/Industry<br><b>Hospital</b>                                                                                                                                                                                                                                                                                                                                                                            |                                          | 17. Father's Name (First, Middle, Last)<br><b>Willie Smith</b>                                                                                                                                                                                                             |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Atlena Fox</b>                                                                                                                                                                                                                                                                                                                                              |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Michael Smith (SON)</b>                                                                    |                                                          | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14117 Armilla Ct Burtonville Md 20866</b>                                                                                                                                                                                                                                                                                |                                          | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oxford Mt. Zion Baptist 7-1-00</b>                                                                                                                                                                                                                                                                                                     |  | 20c. Location - City or Town, State<br><b>Ruther Glen Va</b>                                                                                      |                                                          | 21. Signature of Funeral Service Licensee<br><b>Henry W Dabney Funeral Home</b>                                                                                                                                                                                                                                                                                                                                              |                                          | 22. Name and Address of Facility<br><b>POB 528 Ashland Va</b>                                                                                                                                                                                                              |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Candida Sepsis</b><br>Due to (or as a consequence of):<br><b>billiary tract obstruction</b><br>Due to (or as a consequence of):<br><b>metastatic pancreas ca</b><br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br><b>4/20/00</b><br><b>5/00</b><br><b>4/99</b>                                                      |                                                          | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                             |                                          | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                      |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                             |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |                                                          | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |                                          | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  |
| 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                              |  | 28b. Time of Injury<br><b>M</b>                                                                                                                   |                                                          | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                  |                                          | 28d. Describe how injury occurred                                                                                                                                                                                                                                          |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                              |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |                                                          | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                          | 29b. Signature and title of certifier<br><b>Dr. M. L. Will</b>                                                                                                                                                                                                             |  |
| 29c. License number<br><b>D35176 MD</b>                                                                                                                                                                                                                                                                                                                                                                             |  | 29d. Date signed (Month, Day, Year)<br><b>06/24/00</b>                                                                                            |                                                          | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. M. L. Will 7525 Greenway Ctr. Dr. Greenbelt, Md. 20770</b>                                                                                                                                                                                                                                                                    |                                          | 31. Date filed (Month, Day, Year)<br><b>JUN 27 2000</b>                                                                                                                                                                                                                    |  |
| 32. Registrar's Signature<br><b>John A. Sparks</b>                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                   |                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                          |                                                                                                                                                                                                                                                                            |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

1024

W. J. 11/11/11

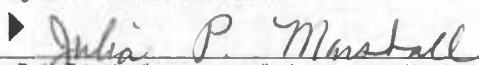
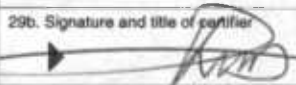
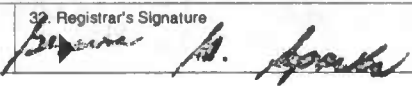
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22304

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |                                       |                                                                                                                                                                                                  |  |                                                                                      |                                                                         |                                                                                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 1. Decedent's Name (First, Middle, Last)<br><b>MARGARET R. SMITH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                       |                                       | 2. Date of Death<br>Month Day Year<br><b>June 22, 2000</b>                                                                                                                                       |  |                                                                                      |                                                                         | 3. Time of Death<br><b>10:50 PM</b>                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 4a. Facility Name (If not institution, give street and number)<br><b>Heartland Health Care Center of Adelphi</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                       |                                       | 4b. City, Town, or Location of Death<br><b>Adelphi</b>                                                                                                                                           |  |                                                                                      |                                                                         | 4c. County of Death<br><b>Prince George's</b>                                                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 5. Social Security Number<br><b>578-30-2020</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                       | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.                                                                                                                                                 |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 25, 1920</b>                          |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Accomack, Virginia</b>                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |                                       |                                                                                                                                                                                                  |  |                                                                                      |                                                                         |                                                                                                  |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 10a. State<br><b>D.C.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. County<br><b>N/A</b>                                                                                                                             |                                       | 10c. City, Town or Location<br><b>Washington</b>                                                                                                                                                 |  |                                                                                      |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 10e. Street and Number<br><b>424 Luray Place N.W.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |                                       | 10f. Zip Code<br><b>20010</b>                                                                                                                                                                    |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                       |                                                                         |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                       |                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic</b>                                                                     |  |                                                                                      | 16b. Kind of Business/Industry<br><b>Self Employed</b>                  |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 17. Father's Name (First, Middle, Last)<br><b>Samuel Ames</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mattie Sample</b>                                                                                                                        |  |                                                                                      |                                                                         |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 19a. Informant's Name/Relationship (Type, Print)<br><b>Levi T. Smith - Son</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                       |                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>424 Luray Pl. N.W. Washington D.C. 20010</b>                                                 |  |                                                                                      |                                                                         |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                                               |                                       | Date<br><b>6-28-00</b>                                                                                                                                                                           |  | 20c. Location - City or Town, State<br><b>Alexandria, VA</b>                         |                                                                         |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |                                       | 22. Name and Address of Facility<br><b>Marshall's Funeral Home, Inc.<br/>4217 9th Street n.W. Washington DC 20011</b>                                                                            |  |                                                                                      |                                                                         |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Urosepsis</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |                                                                                                                                                       |                                       |                                                                                                                                                                                                  |  |                                                                                      |                                                                         |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                       |                                       |                                                                                                                                                                                                  |  |                                                                                      |                                                                         |                                                                                                  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |                                       |                                                                                                                                                                                                  |  |                                                                                      |                                                                         |                                                                                                  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |                                       |                                                                                                                                                                                                  |  |                                                                                      |                                                                         |                                                                                                  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Dementia Contracture</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |                                       |                                                                                                                                                                                                  |  |                                                                                      |                                                                         |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |                                       |                                                                                                                                                                                                  |  |                                                                                      |                                                                         |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                       |                                       |                                                                                                                                                                                                  |  |                                                                                      |                                                                         |                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                         |  | 28a. Date of Injury (Month, Day Year)                                                                                                                 |                                       | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                         | 28d. Describe how injury occurred                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                       |                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |  |                                                                                      |                                                                         |                                                                                                  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |                                       |                                                                                                                                                                                                  |  |                                                                                      |                                                                         |                                                                                                  |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       | 29c. License number<br><b>D 42749</b> |                                                                                                                                                                                                  |  | 29d. Date signed (Month, Day, Year)<br><b>6/26/00</b>                                |                                                                         |                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Raymond Nwadiuko, M.D. 9831 Greenbelt Rd. Suite 101, Lanham, MD 20706</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |                                       |                                                                                                                                                                                                  |  |                                                                                      |                                                                         |                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 27 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |                                       |                                                                                                                                                                                                  |  |                                                                                      |                                                                         |                                                                                                  |  |
| 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |                                       |                                                                                                                                                                                                  |  |                                                                                      |                                                                         |                                                                                                  |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene 00 22305

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Sullivan

2. Date of Death

Month

Day

Year

June

22

2000

2220

3. Time of Death

4a. Facility Name (If not institution, give street and number)

Spa Creek Nursing Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

456-035206

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Nov. 14, 1912

9. Birthplace (State or Foreign Country)

Oklahoma

Usual Residence of Decedent

10a. State

Md.

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1729 Trent Street

10f. Zip Code

21114

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

U.S. Gov't

17. Father's Name (First, Middle, Last)

James Cunningham

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Walker Hatfield

19a. Informant's Name/Relationship (Type, Print)

John L Sullivan/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1729 Trent St., Crofton, Md. 21114

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hillcrest Cemetery

Date

6-28-2000

20c. Location - City or Town, State

Gravette, Ar.

21. Signature of Funeral Service Licensee

Robert G. Beall

M00025

22. Name and Address of Facility

Beall Funeral Home

6512 N.W. Crain Hwy., Bowie, Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter R. Graze, MD

29c. License number

D16364

29d. Date signed (Month, Day, Year)

6/23/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peter R. Graze, MD, 900 Bestgate Rd. #300, Annapolis MD 21401

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22306

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Susan Louise Stup

2. Date of Death

Month Day Year  
June 23, 2000

3. Time of Death

7:00 P.M.

4a. Facility Name (If not institution, give street and number)

2922 Tallow Lane

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

227-80-5309

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 22, 1953

9. Birthplace (State or Foreign Country)

Wash.D.C.

Usual Residence of Decedent

10a. State

Md.

10b. County

Prince Georges

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10111 Cleary Lane

10f. Zip Code

20721

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William B. Mayhew

18. Mother's Name (First, Middle, Maiden Surname)

Marsha Shuey

19a. Informant's Name/Relationship (Type, Print)

Richard P. Stup/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10111 Cleary Lane, Mitchellville, Md.

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory

Date

06-27-00

20c. Location - City or Town, State

Alex.Va.

21. Signature of Funeral Service Licensee

Robert G. Beall

22. Name and Address of Facility

Beall Funeral Home  
6512 N.W.Crain Hwy., Bowie, Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e.

CARDIAC ARREST

Due to (or as a consequence of):

1 minute

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b.

Metastatic Breast Cancer

Due to (or as a consequence of):

3 years

c.

Due to (or as a consequence of):

d.

Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Dtrs.

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Dtrs.

Res.

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D16410

29d. Date signed (Month, Day, Year)

6-26-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gabriel Jaffe 7500 Hanover pkwy Greenbelt, Md. 20770

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

[Signature]

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

15



B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MEO G.786 8-18-00WR.

00 22307

BELINDA BAGLEY AMEND ITEM: #1, 27 PER

Certificate of Death

Reg. No.

|                                                                              |                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                            | 1. Decedent's Name (First, Middle, Last)<br><b>Belinda Bagley Slater</b>                                                                                                       |  |                                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month Day Year<br><b>JULY 1, 2000</b>                                                                                                                                                                                                                  |  |                                                                                                                                                                 |  | 3. Time of Death<br><b>11:37 AM</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |
|                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>25 THURSTON DRIVE</b>                                                                                     |  |                                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><b>UPPER MARLBORO</b>                                                                                                                                                                                                              |  |                                                                                                                                                                 |  | 4c. County of Death<br><b>PRINCE GEORGES</b>                                                                                                                                                                                                                                                                                                                                                                              |  |
| Funeral<br>Director                                                          | 5. Social Security Number<br><b>579-86-8866</b>                                                                                                                                |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>39</b> Yrs.                                                                                                                                                                                                                           |  | If Under 1 Year<br>Months Days                                                                                                                                  |  | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                                                                                                                                                                                                                                            |  |
|                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 19, 1960</b>                                                                                                                    |  | 9. Birthplace (State or Foreign Country)<br><b>Wash., D.C.</b>                                                                                                                                                                                                                                              |  | Usual Residence of Decedent                                                                                                                                                                                                                                                |  | 10a. State<br><b>Md.</b>                                                                                                                                        |  | 10b. County<br><b>Prince Georges</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |
| To Be Completed by Funeral Director                                          | 10c. City, Town or Location<br><b>Upper Marlboro</b>                                                                                                                           |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                              |  | 10e. Street and Number<br><b>25 Thurston Drive</b>                                                                                                                                                                                                                         |  | 10f. Zip Code<br><b>20774</b>                                                                                                                                   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                            |  |
|                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                               |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                         |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>                                                                                                                                                                                                                                                                                                 |  |
| To Be Completed by Physician/Medical Examiner                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Office Manager</b>                                             |  | 16b. Kind of Business/Industry<br><b>Private</b>                                                                                                                                                                                                                                                            |  | 17. Father's Name (First, Middle, Last)<br><b>Cleophus Bagley</b>                                                                                                                                                                                                          |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Josephine Wheaton</b>                                                                                   |  | 19. Informant's Name/Relationship (Type, Print)<br><b>Cleophus Bagley (Father)</b>                                                                                                                                                                                                                                                                                                                                        |  |
|                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>510 Millwoof Dr., Capitol Hgts., Md. 20743</b>                             |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery</b>                                                                                                                                                                      |  | 20c. Location - City or Town, State<br><b>7-6-00 Brentwood, Md.</b>                                                                                             |  | 21. Signature of Funeral Service Licensee<br><b>Philly Bell</b>                                                                                                                                                                                                                                                                                                                                                           |  |
| Physician<br>/Medical<br>Examiner                                            | 22. Name and Address of Facility<br><b>Lewis Funeral Home</b><br><b>311 N. Patrick St., Alexandria, Virginia 22314</b>                                                         |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CHRONIC NARCOTISM</b>                                                                       |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                           |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                           |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                        |  |
|                                                                              | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                              |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>AT SCENE</b> |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)                                                                                                                           |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                           |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                               |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                           |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                     |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                    |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
|                                                                              | 29b. Signature and title of certifier<br><b>J. H. P. M.D.</b>                                                                                                                  |  | 29c. License number<br><b>O.C.M.E</b>                                                                                                                                                                                                                                                                       |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 2, 2000</b>                                                                                                                                                                                                                 |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARY G. RIPPLE, M.D., 111 Penn Street, Baltimore, Maryland 21201</b> |  | 31. Date filed (Month, Day, Year)<br><b>JUL 05 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |  |

ORIGINAL





Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Charles Sciandra

2. Date of Death

Month  
JulyDay  
04Year  
2000

3. Time of Death

9:13 A.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

7400 Greenway Center Drive

4b. City, Town, or Location of Death

Greenbelt

4c. County of Death

Prince George's

5. Social Security Number

220-58-8986

6. Sex

M 2 F

7. Age (In yrs. last birthday)

41

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Month, Day, Year  
Feb. 10, 1959

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

Yes 2 No

10e. Street and Number

6711 Stanton Road

10f. Zip Code

20784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Carpentry

16b. Kind of Business/Industry

Unavailable

17. Father's Name (First, Middle, Last)

Michael C. Sciandra

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Ryhne

19a. Informant's Name/Relationship (Type, Print)

Michael C. Sciandra - Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6711 Stanton Road, Hyattsville, MD 20784

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

7/8/00

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gasch's Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC HYPERTROPHY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HISTORY OF HYPERTHYROIDISM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

28. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

at scene

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 05, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chute

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

60-10879-1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22309

amend item 25 per phys G786 8/31/00 yf

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Albert Savage

2. Date of Death

Month  
MayDay  
29Year  
2000

3. Time of Death

5:50 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

5. Social Security Number

217-36-6588

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

85

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 11, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Mount Airy

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6149 Detrick Road

10f. Zip Code

21771

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Farming

17. Father's Name (First, Middle, Last)

Harry Randolph Savage

18. Mother's Name (First, Middle, Maiden Surname)

Osie Bertha Poole

19a. Informant's Name/Relationship (Type, Print)

Doris Larue Savage - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6149 Detrick Road, Mount Airy, Maryland 21771

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Peter's Cemetery

Date

6/1/00

20c. Location - City or Town, State

Libertytown, Maryland

21. Signature of Funeral Service Licensee

Olin L. Molesworth

22. Name and Address of Facility

Olin L. Molesworth P.A., Funeral Home

26401 Ridge Road, Damascus, Maryland

20872-0117

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aortic Regurgitation

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Sharon B. B. MD

29c. License number

D0054616

29d. Date signed (Month, Day, Year)

May 31, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Sharon B. B. 310 W 9th St. Frederick MD 21701

State  
Registrar

31. Date filed (Month, Day, Year)

MAY 31 2000

32. Registrar's Signature

Sharon B. B.

ORIGINAL

George Albert Savage  
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22310

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM A. SUTHERLAND

2. Date of Death

Month Day Year  
June 25 2000

3. Time of Death

8:35 PM

4a. Facility Name (If not institution, give street and number)

Genesis ElderCare - The Pines

4b. City, Town, or Location of Death

Easton

4c. County of Death

Talbot

Funeral  
Director

5. Social Security Number

214-34-6061

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN. 21, 1937

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

EASTON

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

610 DUTCHMANS LANE

10f. Zip Code

21601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

PAINTER

16b. Kind of Business/Industry

HOME IMPROVEMENT

17. Father's Name (First, Middle, Last)

WILLIAM R. SUTHERLAND

18. Mother's Name (First, Middle, Maiden Surname)

LILLIAN L. MILLER

19a. Informant's Name/Relationship (Type, Print)

DEBBIE A. BUCKLE/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5017 MT. ZION RD HURLOCK, MD 21643

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHESAPEAKE CREMATION CTR 6-26-00 STEVENSVILLE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Joseph M. Ostrowski

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA  
200 S. HARRISON ST. EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. End-stage chronic obstructive lung disease

Approximate Interval Between Onset and Death

years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Rheumatoid arthritis

Atherosclerotic cardiovascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D25933

6-26-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MICHAEL CROWLEY MD 508 IDLEWILD AVENUE EASTON, MD 21801

31. Date filed (Month, Day, Year)

JUN 26 2000

32. Registrar's Signature

B. Sparks

State  
RegistrarWilliam Sutherland  
Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22311

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          |  |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>DONALD STEWART</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  | 2. Date of Death<br>Month Day Year<br><b>JUNE 27, 2000</b>                                                                                                                                        |  | 3. Time of Death<br><b>16:40pm</b>                                                                                                                                                                       |  |
|                                               | 4e. Facility Name (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                         |  | 4b. City, Town, or Location of Death<br><b>Prince Frederick</b>                                                                                                                                   |  | 4c. County of Death<br><b>Calvert</b>                                                                                                                                                                    |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>217-28-1840</b>                                                                                                                                                                                                                                                                                                                                                                                                    |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                              |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.                                                                                                                                                  |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 14, 1932</b>                                                                                                                                              |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                        |  | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                           |  | 10b. County<br><b>Calvert</b>                                                                                                                                                                     |  | 10c. City, Town or Location<br><b>Huntingtown</b>                                                                                                                                                        |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                 |  | 10e. Street and Number<br><b>1710 Kings Landing Road</b>                                                                                                                                                                                                                                                |  | 10f. Zip Code<br><b>20639</b>                                                                                                                                                                     |  | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                              |  |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                             |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                        |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>                                                                                                                                                                           |  | 16b. Kind of Business/Industry<br><b>Construction</b>                                                                                                                                             |  |                                                                                                                                                                                                          |  |
|                                               | 17. Father's Name (First, Middle, Last)<br><b>Clarence Stewart</b>                                                                                                                                                                                                                                                                                                                                                                                 |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Violet Smith</b>                                                                                                                                                                                                                                |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Betty Stewart/Wife</b>                                                                                                                     |  |                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1710 Kings Landing Rd. Huntingtown, MD 20639</b>                                                                                                                                                                                                                                                                                               |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                         |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Zion Hill Church Cem.</b>                                                                                            |  | 20c. Location - City or Town, State<br><b>Lusby, MD</b>                                                                                                                                                  |  |
|                                               | 21. Signature of Funeral Service Licensee<br><b>Blaise A. Sewell</b>                                                                                                                                                                                                                                                                                                                                                                               |  | 22. Name and Address of Facility<br><b>Sewell Funeral Home<br/>1451 Dares Beach Rd. Prince Frederick, MD 20678</b>                                                                                                                                                                                      |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <b>End stage Ca Prostate</b><br>Due to (or as a consequence of):<br>b. <b>CHF, CVA</b><br>Due to (or as a consequence of):<br>c. <b>Cardiomyopathy</b><br>Due to (or as a consequence of):<br>d. <b>Cirrhosis of the liver</b> |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  | Approximate Interval Between Onset and Death                                                                                                                                                             |  |
|                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |  |
|                                               | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                              |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                             |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |  |
|                                               | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                      |  |                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                   |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  | 29b. Signature and title of certifier<br><b>Kioumarce Yazdani</b>                                                                                                                                        |  |
|                                               | 29c. License number<br><b>D17168</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 29d. Date signed (Month, Day, Year)<br><b>6/29/00</b>                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. KIOUMARCE YAZDANI, MD HUNTINGTOWN, MARYLAND 20639</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  | 31. Data filed (Month, Day, Year)<br><b>JUN 30 2000</b>                                                                                                                                                  |  |
|                                               | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Handwritten signature and date "11"

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22312

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY ELIZABETH SALVATORE

2. Date of Death

Month Day Year

June 25 2000

3. Time of Death

0455

4a. Facility Name (If not institution, give street and number)

Washington County Hospital

4b. City, Town, or Location of Death

Hagerstown

4c. County of Death

Washington County

Funeral  
Director

5. Social Security Number

213-12-9179

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 11, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Washington

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

921 Kenwood Drive

10f. Zip Code

21740

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Stock Room Person

16b. Kind of Business/Industry

Ribbon Manufacturing

17. Father's Name (First, Middle, Last)

Courtney A. Fletcher

18. Mother's Name (First, Middle, Maiden Surname)

Grace M. Adams Fletcher

19a. Informant's Name/Relationship (Type, Print)

Harry L. Salvatore/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

921 Kenwood Drive, Hagerstown, Maryland 21740

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rose Hill Cemetery

Date

June 29

20c. Location - City or Town, State

Hagerstown, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Douglas A. Fiery Funeral Home  
1331 Eastern Blvd., N., Hagerstown, Maryland 2174223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. HYPERTENSIVE ARTERIOSCLEROTIC

Due to (or as a consequence of):

CARDIOVASCULAR DISEASE

YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. PERIPHERAL ARTERY INSUFFICIENCY

YEARS

d. Due to (or as a consequence of):  
ARRHYTHMIA

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GLUCOSE INTOLERANCE  
HIATAL HERNIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

A22043

29d. Date signed (Month, Day, Year)

JUNE 26, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11110 MEDICAL CAMPUS RD #130 HAGERSTOWN, MD

31. Date filed (Month, Day, Year)

JUN 30 2000

32. Registrar's Signature

State  
Registrar

Salvatore, Mary

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,  
Baltimore, Maryland 21215-0020To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and is  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. The first part of the report  
describes the general situation  
of the country and the  
state of the economy.

2. The second part of the report  
describes the results of the  
survey and the findings of the  
research.

3. The third part of the report  
describes the conclusions of the  
research and the recommendations  
for further action.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22313

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Earl Simmons</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  | 2. Date of Death<br>Month Day Year<br><b>June 30 2000</b>                                                                                                                                    |  |                                                                                             |                                                                         | 3. Time of Death<br><b>3:07pm</b>                                                              |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>                                                                                                                                     |  |                                                                                             |                                                                         | 4c. County of Death<br><b>MONTGOMERY</b>                                                       |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>215-46-1543</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.                                                                                                                                             |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 30, 1948</b>                                |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Washington D.C.</b>                             |  |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10b. County<br><b>Frederick</b>                                                                                                                   |  | 10c. City, Town or Location<br><b>Monrovia</b>                                                                                                                                               |  |                                                                                             |                                                                         | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                               | 10e. Street and Number<br><b>3127 Kemptown Church Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   |  | 10f. Zip Code<br><b>21770</b>                                                                                                                                                                |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |                                                                         |                                                                                                |  |
|                                               | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                |  |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Transportation Specialist</b>     |  |                                                                                                                                                                                              |  | 16b. Kind of Business/Industry<br><b>Public Schools</b>                                     |                                                                         |                                                                                                |  |
|                                               | 17. Father's Name (First, Middle, Last)<br><b>Richard Allen Simmons</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>June Wenrick</b>                                                                                                                     |  |                                                                                             |                                                                         |                                                                                                |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Paula Long-Simmons/ Wife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3127 Kemptown Church Road, Monrovia, Md 21770</b>                                        |  |                                                                                             |                                                                         |                                                                                                |  |
|                                               | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park 7/6/2000</b>                                  |  |                                                                                                                                                                                              |  | 20c. Location - City or Town, State<br><b>Rockville, Maryland</b>                           |                                                                         |                                                                                                |  |
|                                               | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                   |  | 22. Name and Address of Facility<br><b>Olin L. Molesworth P. A. Funeral Home<br/>26401 Ridge Road, Damascus, Maryland 20872</b>                                                              |  |                                                                                             |                                                                         |                                                                                                |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Acute myocardial infarction</b><br>Due to (or as a consequence of):<br><br>b. <b>Coronary artery disease</b><br>Due to (or as a consequence of):<br><br>c. <b>Hypertension</b><br>Due to (or as a consequence of):<br><br>d. <b>Diabetes mellitus Type II</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |
|                                               | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |
|                                               | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |
|                                               | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |
|                                               | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |
|                                               | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |
| To Be Completed by Physician/Medical Examiner | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                         | 28d. Describe how injury occurred                                                              |  |
|                                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |  |                                                                                             |                                                                         |                                                                                                |  |
|                                               | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |
|                                               | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  | 29c. License number<br><b>D37024</b>                                                                                                                                                         |  | 29d. Date signed (Month, Day, Year)<br><b>June 30, 2000</b>                                 |                                                                         |                                                                                                |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David Srouer M.D. SGH 9901 Medical Center Drive Rockville, Maryland 20850</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>JUL 03 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  | 32. Registrar's Signature<br>                                                                                                                                                                |  |                                                                                             |                                                                         |                                                                                                |  |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22314

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles William Stouts

2. Date of Death

June

Day

30

Year

2000

3. Time of Death

11:30pm

4a. Facility Name (If not Institution, give street and number)

1221 Mountain Church Road

4b. City, Town, or Location of Death

Middletown

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

214-32-4768

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Jan 25 1934

9. Birthplace (State or Foreign Country)

Frederick, MD

Usual Residence of Decedent

10a. State

MD

10b. County

Frederick

10c. City, Town or Location

Middletown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1221 Mountain Church Road

10f. Zip Code

21769

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

Vindobona Nursing  
Home

17. Father's Name (First, Middle, Last)

Alvie Sidney Stouts

18. Mother's Name (First, Middle, Maiden Surname)

Irene Isabell Waters

19a. Informant's Name/Relationship (Type, Print)

Carol Zeisweiss, Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1221 Mountain Church Road, Middletown, MD 21769

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Union Cemetery

Date

7/4/00

20c. Location - City or Town, State

Lovettsville, VA

21. Signature of Funeral Service Licensee

Barbara A. Williams, Owner

22. Name and Address of Facility

John T. Williams Funeral Home  
100 Petersville Road, Brunswick, MD 2171623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Non Small cell lung Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 y

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Barbara A. Williams MD

29c. License number

D48184

29d. Date signed (Month, Day, Year)

7/3/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Elhamy Eskander MD 501 W 7th street Frederick MD 21701

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 03 2000

32. Registrar's Signature

Barbara A. Williams

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22315

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond Melville Scott

2. Date of Death

Month Day Year  
June 21, 2000

3. Time of Death

2:15 am

4a. Facility Name (If not institution, give street and number)

Frederick Memorial Hospital

4b. City, Town, or Location of Death

Frederick

4c. County of Death

Frederick

Funeral  
Director

5. Social Security Number

706-18-6031

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

85 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov 25, 1914

9. Birthplace (State or Foreign Country)

New Jersey

Usual Residence of Decedent

10a. State

Maryland

10b. County

Frederick

10c. City, Town or Location

Frederick

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

5820 Genesis Lane, # 523

10f. Zip Code

21703

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Representative

16b. Kind of Business/Industry

Allis Chalmers Comp

17. Father's Name (First, Middle, Last)

Raymond

Scott

18. Mother's Name (First, Middle, Maiden Surname)

Mary

Wheeler

19a. Informant's Name/Relationship (Type, Print)

Joan S. Luedtke, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11137 Rutledge Drive, Gaithersburg, MD 20878

20a. Method of Disposition

☒ Burial ☐ Cremation ☒ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

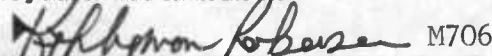
Colestown Cemetery Jun 24, 2000

Data

20c. Location - City or Town, State

Cherry Hill, New Jersey

21. Signature of Funeral Service Licensee

 M706

22. Name and Address of Facility

Keeney & Basford P.A. Funeral Home  
106 E Church Street, Frederick, Maryland 21701

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 MONTH

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. MYELODYSPLASIA OF THE BONE MARROW

Due to (or as a consequence of):

6 MONTHS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

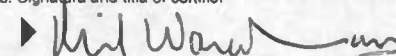
28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D47611

29d. Date signed (Month, Day, Year)

June 21, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Neil V. Waradekar, M.D., 1475 Taney Ave, #204, Frederick, Maryland 21702-5127

31. Date filed (Month, Day, Year)

JUN 27 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22316

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br><b>DORIS ANN SWAIN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               | 2. Date of Death<br>Month Day Year<br><b>July 1 2000</b>                                                                                                                                         |                                                                                      |                                                              |                                                                         | 3. Time of Death<br><b>1:50 PM</b>                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br><b>9024 Holly Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               | 4b. City, Town, or Location of Death<br><b>Waldorf</b>                                                                                                                                           |                                                                                      |                                                              |                                                                         | 4c. County of Death<br><b>Charles</b>                                                              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br><b>223-40-9461</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                    | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>63</b>                                                                                                                                                      |                                                                                      | 8. Date of Birth (Month, Day, Year)<br><b>AUG 23 1936</b>    |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                              | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                    | 10b. County<br><b>Charles</b>                                                                                                                         |                                                                                                                               | 10c. City, Town or Location<br><b>Waldorf</b>                                                                                                                                                    |                                                                                      |                                                              |                                                                         | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10e. Street and Number<br><b>9024 Holly Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               | 10f. Zip Code<br><b>20601</b>                                                                                                                                                                    |                                                                                      | 10g. Citizen of What Country?<br><b>USA</b>                  |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                      |                                                              | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                    |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b> |                                                                                                                                                                                                  |                                                                                      | 16b. Kind of Business/Industry<br><b>Own Home</b>            |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. Father's Name (First, Middle, Last)<br><b>Edward B. LaCovey</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gladys King LaCovey</b>                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                    | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathy Swain Leighty (Daughter)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9024 Holly Avenue Waldorf, MD 20601</b>                                                      |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                                               |                                                                                                                               | 20c. Date<br><b>7-4-00</b>                                                                                                                                                                       |                                                                                      | 20d. Location - City or Town, State<br><b>Alexandria, VA</b> |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. Signature of Funeral Service Licensee<br> <b>M00173</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                    | 22. Name and Address of Facility<br><b>Eberwein Funeral Services<br/>4433 White Pls La White Pls., MD 20695</b>                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Stomach Cancer</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 28a. Date of Injury (Month, Day Year)                                                                                              |                                                                                                                                                       | 28b. Time of Injury<br><b>M</b>                                                                                               |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                              | 28d. Describe how injury occurred                                       |                                                                                                    |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                       |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
| 29b. Signature and title of certifier<br> <b>H. Mathur</b>                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                    |                                                                                                                                                       | 29c. License number<br><b>D28352</b>                                                                                          |                                                                                                                                                                                                  | 29d. Date signed (Month, Day, Year)<br><b>July 3, 2000</b>                           |                                                              |                                                                         |                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646</b>                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                    |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 05 2000</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 32. Registrar's Signature<br> <b>B. Sparks</b> |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                      |                                                              |                                                                         |                                                                                                    |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22317

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2020.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                                   |                                                                                                |                                                                                                                                                                                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>RALPH LEE SPARROW, SR.</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |                                                  | 2. Date of Death<br>Month <b>6</b> Day <b>20</b> Year <b>2000</b>                                                                                                                               |                                                   | 3. Time of Death<br><b>8:30 AM</b>                                                             |                                                                                                                                                                                                  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Atlantic General Hospital</b>                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |                                                  | 4b. City, Town, or Location of Death<br><b>Berlin</b>                                                                                                                                           |                                                   | 4c. County of Death<br><b>Worcester</b>                                                        |                                                                                                                                                                                                  |
| 5. Social Security Number<br><b>216-38-3750</b>                                                                                                                                                                                                                                                                                                                                                                                           |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs. | If Under 1 Year<br>Month <b>11</b> Day <b>16</b>                                                                                                                                                | If Under 24 Hrs.<br>Hour <b>11</b> Min. <b>16</b> | 8. Date of Birth (Month, Day, Year)<br><b>11/16/1940</b>                                       |                                                                                                                                                                                                  |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                                   |                                                                                                |                                                                                                                                                                                                  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10b. County<br><b>Worcester</b>                                                                                                                                                                                                                                                             |                                                  | 10c. City, Town or Location<br><b>Ocean City</b>                                                                                                                                                |                                                   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                  |
| 10e. Street and Number<br><b>219 South Ocean Dr.</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |                                                  | 10f. Zip Code<br><b>21842</b>                                                                                                                                                                   |                                                   | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                                                                                                                                                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                            |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1959-63</b>                                                                                                                            |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                        |                                                                                                                                                                                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Engineer</b>                                                                    |                                                   | 16b. Kind of Business/Industry<br><b>Intelligence/Satellites</b>                               |                                                                                                                                                                                                  |
| 17. Father's Name (First, Middle, Last)<br><b>Russell Sparrow</b>                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy (Unknown)</b>                                                                                                                   |                                                   |                                                                                                |                                                                                                                                                                                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Sue H. Harting/ Friend</b>                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>219 South Ocean Dr. Ocean City, MD 21842</b>                                                |                                                   |                                                                                                |                                                                                                                                                                                                  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                     |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cape Henlopen Crematory</b>                                                                                                                                                                                    |                                                  | Date<br><b>6/24/00</b>                                                                                                                                                                          |                                                   | 20c. Location - City or Town, State<br><b>Frankford, DE</b>                                    |                                                                                                                                                                                                  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |                                                  | 22. Name and Address of Facility<br><b>Burbage Funeral Home</b><br><b>108 William St. Berlin, MD 21811</b>                                                                                      |                                                   |                                                                                                |                                                                                                                                                                                                  |
| 23a. Present, chronic disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Metastatic Colon CA</b><br>a. Due to (or as a consequence of):<br><br><b>Malnutrition</b><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                                   |                                                                                                | Approximate Interval Between Onset and Death                                                                                                                                                     |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                                   |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                                   |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                         |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                                                                                 |                                                   |                                                                                                |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                   |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                 |                                                   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |                                                                                                                                                                                                  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |                                                   |                                                                                                |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.              |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                                   |                                                                                                |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |                                                  | 29c. License number<br><b>H0053714</b>                                                                                                                                                          |                                                   | 29d. Date signed (Month, Day, Year)<br><b>6/20/00</b>                                          |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jeffrey Matzoni, DO 9714 Healthway Dr. Berlin, MD 21811</b>                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                                                                                 |                                                   |                                                                                                |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 23 2000</b>                                                                                                                                                                                                                                                                                                                                                                                   |  | 32. Registrar's Signature<br>                                                                                                                                                                           |                                                  |                                                                                                                                                                                                 |                                                   |                                                                                                |                                                                                                                                                                                                  |

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22318

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIAM E. SAVAGE

2. Date of Death  
Month Day Year  
06/16/003. Time of Death  
8:00 amFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Mallard Bay Care Center

4b. City, Town, or Location of Death

Cambridge

4c. County of Death

Dorchester

5. Social Security Number

213-24-4703

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
03/04/25

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

VA

10b. County

Accomack

10c. City, Town or Location

Atlantic

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

32333 Wishart Point Road

10f. Zip Code

23303

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 46 - '45

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

4th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Seafood

17. Father's Name (First, Middle, Last)

Levin Brown

18. Mother's Name (First, Middle, Maiden Surname)

Ardonia Watson

19a. Informant's Name/Relationship (Type, Print)

Ovie Williams/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. Box 111, Atlantic, VA 23303

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Taylor Cemetery

Date

6/24/00

20c. Location - City or Town, State

Atlantic, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

COOPER &amp; HUMBLE FUNERAL CO., INC.

P. O. Box 176, Accomack, VA 23301

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Severe Peripheral Vascular Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Malnutrition

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Signature MD

29c. License number

D 47924

29d. Date signed (Month, Day, Year)

6-16-00

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

NOMAN THAWNY 300 AURORA ST. CAMBRIDGE MD 21613

State  
Registrar

31. Date filed (Month, Day, Year)

JUN 23 2000

32. Registrar's Signature

Signature B. Sparks

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22319

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                |  |                                                                                                                                                                                                  |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Marcia Thomas</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                   |  | 2. Date of Death<br>Month <b>06</b> Day <b>27</b> Year <b>2000</b>                                                                                                                                                                                                                          |  |                                                                                                                                                  |  | 3. Time of Death <b>5:20 AM</b>                                                                |  |                                                                                                                                                                                                  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>University of Maryland Medical Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br><b>Baltimore, MD</b>                                                                                                                                                                                                                                |  |                                                                                                                                                  |  | 4c. County of Death<br><b>Baltimore City</b>                                                   |  |                                                                                                                                                                                                  |  |
| 5. Social Security Number<br><b>577-70-0110</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>48</b>                                                                                                                                                                                                                                                 |  | 8. Date of Birth (Month, Day, Year)<br><b>2-8-52</b>                                                                                             |  | 9. Birthplace (State or Foreign Country)<br><b>Wash., D.C.</b>                                 |  |                                                                                                                                                                                                  |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                |  |                                                                                                                                                                                                  |  |
| 10a. State<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10b. County<br><b>Prince Georges</b>                                                                                                              |  | 10c. City, Town or Location<br><b>Landover</b>                                                                                                                                                                                                                                              |  |                                                                                                                                                  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |                                                                                                                                                                                                  |  |
| 10e. Street and Number<br><b>2410- Brightseat Road #2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  | 10f. Zip Code<br><b>20785</b>                                                                                                                                                                                                                                                               |  |                                                                                                                                                  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                 |  |                                                                                                                                                                                                  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                |  |                                                                                                                                                  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |                                                                                                                                                                                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+) 3+</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Dental Assistance</b>                                                                                                                                                       |  |                                                                                                                                                  |  | 16b. Kind of Business/Industry<br><b>N/A</b>                                                   |  |                                                                                                                                                                                                  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Lawrence Bloomfield</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Watson</b>                                                                       |  |                                                                                                |  |                                                                                                                                                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lolita G. Bolade/Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3011- Georgia Ave., N.W. Wash., DC 20011</b> |  |                                                                                                |  |                                                                                                                                                                                                  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glenwood Cemetery</b>                                                                                                                                                                                          |  | Date<br><b>7/1/00</b>                                                                                                                            |  | 20c. Location - City or Town, State<br><b>Washington, D.C.</b>                                 |  |                                                                                                                                                                                                  |  |
| 21. Signature of Funeral Service Licensee<br><b>Shelton W. Hackett</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  | 22. Name and Address of Facility<br><b>Hackett's Funeral Chapel, Inc.<br/>814- Upshur Street, N.W.</b>                                                                                                                                                                                      |  |                                                                                                                                                  |  |                                                                                                |  |                                                                                                                                                                                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>End Stage Renal Disease</b><br>Due to (or as a consequence of):<br>b. <b>Diabetes Mellitus</b><br>Due to (or as a consequence of):<br>c. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>d. |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                |  | Approximate Interval Between Onset and Death<br><br><b>years</b><br><br><b>years</b><br><br><b>years</b>                                                                                         |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                  |  |                                                                                                |  |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |  | 28b. Time of Injury<br><b>M</b>                                                                                                                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  | 28d. Describe how injury occurred                                                                                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  |                                                                                                                                                  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |                                                                                                                                                                                                  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                |  |                                                                                                                                                                                                  |  |
| 29b. Signature and title of certifier<br><b>Dr. Jeffrey Lesser M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  | 29c. License number<br><b>13129</b>                                                                                                                                                                                                                                                         |  |                                                                                                                                                  |  | 29d. Date signed (Month, Day, Year)<br><b>6/27/00</b>                                          |  |                                                                                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Jeffrey Lesser<br/>Care of Department of Medicine 22 S. Greene St. Baltimore, MD 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                |  |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 29 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                             |  |                                                                                                                                                  |  |                                                                                                |  |                                                                                                                                                                                                  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22320

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Gladys Rebecca Thompson                           |  |                                                                                                                                                                                                                                                                                                         |  | 2. Date of Death<br>Month Day Year<br>June 22 2000 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 3. Time of Death<br>6530                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>Dorchester General Hospital |  |                                                                                                                                                                                                                                                                                                         |  | 4b. City, Town, or Location of Death<br>Cambridge  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4c. County of Death<br>Dorchester                                                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>214-07-8684                                                      |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 7. Age (In yrs. last birthday)<br>92 Yrs.          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 8. Date of Birth (Month, Day, Year)<br>July 10, 1907                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 9. Birthplace (State or Foreign Country)<br>Virginia                                          |  | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                  |  | 10b. County<br>Dorchester                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 10c. City, Town or Location<br>Cambridge                                             |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               |  | 10b. County<br>Dorchester                                                                                                                                                                                                                                                                               |  |                                                    | 10c. City, Town or Location<br>Cambridge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                      |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |                                                                                               |  | 10e. Street and Number<br>620 Greenwood Ave.                                                                                                                                                                                                                                                            |  |                                                    | 10f. Zip Code<br>21613                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                      |  |
| 10g. Citizen of What Country?<br>USA                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                  |  |                                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                      |  |
| 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                              |                                                                                               |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                                                                                                                                                                                                                        |  |                                                    | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 2 College (1-4 or 5+) 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                      |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Cook                                                                                                                                                                                                                                                                                                             |                                                                                               |  | 16b. Kind of Business/Industry<br>Restaurants/ Private Families                                                                                                                                                                                                                                         |  |                                                    | 17. Father's Name (First, Middle, Last)<br>Nathaniel King                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                      |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br>Unknown                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |  | 19a. Informant's Name/Relationship (Type, Print)<br>Lavonya Thompson /Grand daughter                                                                                                                                                                                                                    |  |                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>620 Greenwood Ave., Cambridge, Maryland 21613                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                      |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                               |                                                                                               |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Waugh Cemetery                                                                                                                                                                                                                |  |                                                    | 20c. Location - City or Town, State<br>6/27/2000 Cambridge, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                      |  |
| 21. Signature of Funeral Service Licensee                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                               |  | 22. Name and Address of Facility<br>Bennie Smith Funeral Home<br>P.O. Box 1687, Easton, Maryland 21601                                                                                                                                                                                                  |  |                                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Hyperosmolar Syndrome<br>Due to (or as a consequence of):<br>b. Acidosis<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                      |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                      |                                                                                               |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                               |  |                                                    | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                      |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Chronic debilitated state<br>Dementia                                                                                                                                                                                                                                                               |                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                               |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                               |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |  | 28b. Time of Injury<br>M                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                               |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |  |                                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                      |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |  |
| 29b. Signature and title of certifier<br>Michael Friedman MD                                                                                                                                                                                                                                                                                                                                                                  |                                                                                               |  | 29c. License number<br>D26388                                                                                                                                                                                                                                                                           |  |                                                    | 29d. Date signed (Month, Day, Year)<br>June 22, 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Michael Friedman MD 302 Collins Harlock MD 21643                                                                                                                                                                                                                                                                                      |                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |  |
| 31. Date filed (Month, Day, Year)<br>JUN 30 2000                                                                                                                                                                                                                                                                                                                                                                              |                                                                                               |  | 32. Registrar's Signature<br>B. Sparks                                                                                                                                                                                                                                                                  |  |                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                      |  |



Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                                                |  |                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>BERHANU TUAFFE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        | 2. Date of Death<br>Month Day Year<br><b>JUNE 20 2000</b>                                                                                                                                    |                                                                                                                                                                                                  | 3. Time of Death<br><b>21:08 PM</b>                                                            |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>3450 TOLEDO TERRACE APARTMENT 617</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        | 4b. City, Town, or Location of Death<br><b>HYATTSVILLE</b>                                                                                                                                   |                                                                                                                                                                                                  | 4c. County of Death<br><b>PRINCE GEORGE'S</b>                                                  |  |                                              |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>212-39-6087</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                          | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |                                        | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs.                                                                                                                                             |                                                                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>February 18, 1953</b>                                |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 9. Birthplace (State or Foreign Country)<br><b>Ethiopia, East Africa</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                                                |  |                                              |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                                                |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                          | 10b. County<br><b>Prince George's</b>                                                                                                             |                                        | 10c. City, Town or Location<br><b>Hyattsville</b>                                                                                                                                            |                                                                                                                                                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>3450 Toledo Terrace, Apt #617</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        | 10f. Zip Code<br><b>20782</b>                                                                                                                                                                |                                                                                                                                                                                                  | 10g. Citizen of What Country?<br><b>Ethiopia, East Africa</b>                                  |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                        | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Engineer</b>                      |                                        | 16b. Kind of Business/Industry<br><b>Private</b>                                                                                                                                             |                                                                                                                                                                                                  |                                                                                                |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. Father's Name (First, Middle, Last)<br><b>Tuaaffe Atria</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Zewdiu Ayele</b>                                                                                                                     |                                                                                                                                                                                                  |                                                                                                |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Yetemwork Teferra/Wife</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3450 Toledo Terrace, #617, Hyattsville, MD 20782</b>                                     |                                                                                                                                                                                                  |                                                                                                |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery 2000</b>                                       |                                        | Date<br><b>06/26</b>                                                                                                                                                                         |                                                                                                                                                                                                  | 20c. Location - City or Town, State<br><b>Brentwood, Maryland</b>                              |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br><b>Nancy A. Perante</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        | 22. Name and Address of Facility<br><b>J. B. JENKINS FUNERAL HOME<br/>7474 Landover Road, Landover, Maryland 20785</b>                                                                       |                                                                                                                                                                                                  |                                                                                                |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiac Arrhythmia</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                                                |  | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        |                                                                                                                                                                                              | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                                                                |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        |                                                                                                                                                                                              | 24e. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                            |                                                                                                |  |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        |                                                                                                                                                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                               |                                                                                                |  |                                              |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |                                                                                                                                                   |                                        |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                                                |  |                                              |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                    |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>        |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                 |                                                                                                |  |                                              |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   | 28d. Describe how injury occurred      |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                                                |  |                                              |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 29b. Signature and title of certifier<br><b>Theodore M. King</b>                                                                                                                                                                                                                                         |                                                                                                                                                   | 29c. License number<br><b>O.C.M.E.</b> |                                                                                                                                                                                              | 29d. Date signed (Month, Day, Year)<br><b>JUNE 21, 2000</b>                                                                                                                                      |                                                                                                |  |                                              |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>THEODORE M. King 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                                                |  |                                              |
| 31. Date filed (Month, Day, Year)<br><b>JUN 26 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                          |                                                                                                                                                   |                                        |                                                                                                                                                                                              |                                                                                                                                                                                                  |                                                                                                |  |                                              |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

22



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22322

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kent

Viehoever

2. Date of Death  
Month Day Year

June 25 2000

3. Time of Death

6:55 PM

4a. Facility Name (If not institution, give street and number)

109 Seneca Drive

4b. City, Town, or Location of Death

Forest Heights

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

119-24-0451

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Aug. 17, 1926

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Forest Heights

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

109 Seneca Drive

10f. Zip Code

20745

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1944-

1946

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

8+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Research Psychologist

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Arno

Viehoever

18. Mother's Name (First, Middle, Maiden Summa)

Mabel

Johnson

19a. Informant's Name/Relationship (Type, Print)

Mark Viehoever (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11111 Riverview Road Ft. Washington, Maryland 20744

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee Crematory

Date

June 27, 2000

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Lee Funeral Home, Inc.

6633 Old Alexandria Ferry Road Clinton, MD 20735

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. BLadder Cancer with Metastasis

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

N/A

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

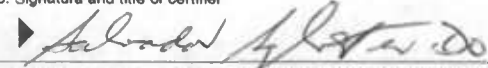
28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

H0055927

29d. Date signed (Month, Day, Year)

June 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Salvador S. Sykes, 3001 Hospital Drive, Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22323

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |                                                                                                                                                                                                  |  |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>WILBUR LLOYD WISEMAN</b>                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month Day Year<br><b>June 26, 2000</b>                                                                                                                                   |  |                                                                                             |                                                                         | 3. Time of Death<br><b>~ 12:20 AM</b>                                                          |  |                                                                                                                                                                                                  |  |
|                                               | 4e. Facility Name (If not institution, give street and number)<br><b>7011 Farragut Street</b>                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><b>Hyattsville</b>                                                                                                                                   |  |                                                                                             |                                                                         | 4c. County of Death<br><b>Prince George's</b>                                                  |  |                                                                                                                                                                                                  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>578-40-4485</b>                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.                                                                                                                                             |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept 21, 1931</b>                                 |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>                            |  |                                                                                                                                                                                                  |  |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |                                                                                                                                                                                                  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. County<br><b>Prince George's</b>                                                                                                                                                                                                                                                       |  | 10c. City, Town or Location<br><b>Hyattsville</b>                                                                                                                                            |  |                                                                                             |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |                                                                                                                                                                                                  |  |
|                                               | 10e. Street and Number<br><b>7011 Farragut Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 10f. Zip Code<br><b>20784</b>                                                                                                                                                                |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                              |                                                                         |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                               | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                      |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1953-1957</b>                                                                                                                          |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>College (1-4 or 5+)</b><br><b>1 yr.</b>                                                                                                                                                                                                                                                                                                                                        |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Postal Worker</b>                                                                                                                                                           |  |                                                                                                                                                                                              |  | 16b. Kind of Business/Industry<br><b>U.S. Postal Service</b>                                |                                                                         |                                                                                                |  |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Elmer Wiseman</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Nellie Lee</b>                                                                                                                       |  |                                                                                             |                                                                         |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                               | 19a. Informant's Name/Relationship (Type, Print)<br><b>Esther Wynn - Sister</b>                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6930 Emerson Street Hyattsville MD 20784</b>                                             |  |                                                                                             |                                                                         |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                               | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                               |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                                                                                                                                                                                     |  | 20c. Date<br><b>6-28-00</b>                                                                                                                                                                  |  | 20d. Location - City or Town, State<br><b>Alex VA</b>                                       |                                                                         |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                               | 21. Signature of Funeral Service Licensee<br><i>Julia P. Marshall</i>                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 22. Name and Address of Facility<br><b>Marshall's Funeral Home, Inc.</b><br><b>4217 9th Street N.W. Washington DC 20011</b>                                                                  |  |                                                                                             |                                                                         |                                                                                                |  |                                                                                                                                                                                                  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cardiac arrest</b><br>Due to (or as a consequence of):<br><b>b. Hypertension</b><br>Due to (or as a consequence of):<br><b>c. alcohol abuse</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  | Approximate Interval Between Onset and Death                                                                                                                                                     |  |
|                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |  |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                               | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                       |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                         | 28d. Describe how injury occurred                                                              |  |                                                                                                                                                                                                  |  |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  |                                                                                                                                                                                              |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |                                                                         |                                                                                                |  |                                                                                                                                                                                                  |  |
|                                               | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                        |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |                                                                                                                                                                                                  |  |
| State Registrar                               | 29b. Signature and title of certifier<br><i>Samuel Semegen, MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 29c. License number<br><b>D 48152</b>                                                                                                                                                        |  |                                                                                             |                                                                         | 29d. Date signed (Month, Day, Year)<br><b>6/28/2000</b>                                        |  |                                                                                                                                                                                                  |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Samuel Semegen, MD 1221 Mercantile Lane, Upper Marlboro, MD 20724</b>                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                |  |                                                                                                                                                                                                  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>JUN 30 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 32. Registrar's Signature<br><i>Samuel Semegen</i>                                                                                                                                           |  |                                                                                             |                                                                         |                                                                                                |  |                                                                                                                                                                                                  |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 22324

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                          |                                                                                                                                                                                                  |                                                                                  |                                |                                                      |                                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|--------------------------------|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br>RODERIC ALONSO WELCHER, SR.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                          | 2. Date of Death<br>Month Day Year<br>June 27, 2000                                                                                                                                              |                                                                                  |                                |                                                      | 3. Time of Death<br>4:10AM                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br>Pineview Nursing Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                          | 4b. City, Town, or Location of Death<br>Clinton                                                                                                                                                  |                                                                                  |                                |                                                      | 4c. County of Death<br>Prince Georges                                                                                                   |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br>577-66-7063                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                |                          | 7. Age (In yrs. last birthday)<br>52 Yrs.                                                                                                                                                        |                                                                                  | If Under 1 Year<br>Months Days |                                                      | If Under 24 Hrs.<br>Hours Min.                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br>03-14-48                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br>Wash. D.C.                                                                                                    |                          | 10a. State<br>Maryland                                                                                                                                                                           |                                                                                  | 10b. County<br>Prince George's |                                                      | 10c. City, Town or Location<br>Suitland                                                                                                 |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             | 10e. Street and Number<br>3827 St. Barnabus Road, # 103                                                                                                   |                          |                                                                                                                                                                                                  |                                                                                  | 10f. Zip Code<br>20746         |                                                      | 10g. Citizen of What Country?<br>USA                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1967-68 |                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:    |                                                                                  |                                |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+) 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Cook                                                                                |                                                                                  |                                |                                                      | 16b. Kind of Business/Industry<br>Restuarant                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. Father's Name (First, Middle, Last)<br>Cleophas Welcher                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                          | 18. Mother's Name (First, Middle, Maiden Surname)<br>Justice O. Hill                                                                                                                             |                                                                                  |                                |                                                      |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br>Marcia Claggett                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                          | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3827 St. Barnabus Rd., Suitland, MD 20746                                                       |                                                                                  |                                |                                                      |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Maryland Veterans Cemetery 6/30/00Cheltenham, MD                                                                       |                                                                                  |                                |                                                      | 20c. Location - City or Town, State                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br><i>Strickland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                          | 22. Name and Address of Facility<br>Strickland Funeral Services, P.A.<br>6500 Allentown Road, Camp Springs, MD 20748                                                                             |                                                                                  |                                |                                                      |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. CANCER OF THE LUNG WITH METASTASES<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                          | Approximate Interval Between Onset and Death<br>MONTHS                                                                                                                                           |                                                                                  |                                |                                                      |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                          | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                                  |                                |                                                      |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                          | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                                                  |                                |                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                           |                          |                                                                                                                                                                                                  |                                                                                  |                                |                                                      |                                                                                                                                         |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                                                           | 28b. Time of Injury<br>M |                                                                                                                                                                                                  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                | 28d. Describe how injury occurred                    |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                                                           |                          |                                                                                                                                                                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |                                |                                                      |                                                                                                                                         |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 29b. Signature and title of certifier<br><i>ALO</i>                                                                                                                                                                                                                                         |                                                                                                                                                           |                          |                                                                                                                                                                                                  | 29c. License number<br>D-18545                                                   |                                | 29d. Date signed (Month, Day, Year)<br>JUNE 27, 2000 |                                                                                                                                         |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>P. WISOTSKY AD. 12070 OLD LINE CENTER WARDEN, Md. 20602                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 31. Date filed (Month, Day, Year)<br>JUN 29 2000                                                                                                                                                                                                                                            |                                                                                                                                                           |                          |                                                                                                                                                                                                  |                                                                                  |                                |                                                      |                                                                                                                                         |  |
| 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                                                                                                           |                          |                                                                                                                                                                                                  |                                                                                  |                                |                                                      |                                                                                                                                         |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22325

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jacqueline Lee Wright

2. Date of Death

Month Day Year  
June 26, 2000

3. Time of Death

10:00 Am

4a. Facility Name (If not institution, give street and number)

8886 Washington Street

4b. City, Town, or Location of Death

Savage

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

215-52-5334

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
January 28, 1949

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Savage

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8886 Washington Street

10f. Zip Code

20763

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Jack Coleman Rainey

18. Mother's Name (First, Middle, Maiden Surname)

Florence Theresa Fauth

19a. Informant's Name/Relationship (Type, Print)

Andrew Wright (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8886 Washington Street Savage Maryland 20763

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Crematory

Date

7-1-00

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Fort Lincoln Funeral Home Inc  
3401 Bladensburg Rd, Brentwood Md 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Non Small Cell Lung Cancer  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

9 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Julie R Brahmer MD

29c. License number

D00051770

29d. Date signed (Month, Day, Year)

June, 28, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julie R Brahmer MD Johns Hopkins Hospital Baltimore, MD 21287

31. Date filed (Month, Day, Year)

JUN 29 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

(3)





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22327

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Martha Dowdy Wyche

2. Date of Death

June 27, 2000

3. Time of Death

12:38 AM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

238 587112

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Jan 13, 1905

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

NC

10b. County

10c. City, Town or Location

Washington

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

129 W. 6th Street

10f. Zip Code

27889

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4or 5+)

5+

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Public School

17. Father's Name (First, Middle, Last)

Moses Dowdy

18. Mother's Name (First, Middle, Maiden Surname)

Joanna Hunter

19a. Informant's Name/Relationship (Type, Print)

Melville Q. Wyche Jr. son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11903 St. Francis Way, Bowie, Maryland

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

6/29/00

20c. Location - City or Town, State

Washington, NC

21. Signature of Funeral Service Licensee

Nelson E. Green

22. Name and Address of Facility

Greene Funeral Home Inc  
814 Franklin St. Alexandria, VA 22314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. STREPTOCOCCUS SEPSIS

Due to (or as a consequence of):

b. strep. pneumoniae

Due to (or as a consequence of):

c. subendocardial MI

Due to (or as a consequence of):

d. thoracoabdominal Aneurysm

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MPINGA

29c. License number

D54357

29d. Date signed (Month, Day, Year)

6/27/00

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MPINGA 3001 Hospital Drive Cheverly, MD 20785

31. Date filed (Month, Day, Year)

JUN 28 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

7-5/5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22328

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Jerome Wahl Williams</b>                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 2. Date of Death<br>Month Day Year<br><b>June 20 2000</b>                                                                                                                                                                                                                     |  | 3. Time of Death<br><b>1613</b>                                                                                                                                                                                                                         |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital</b>                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4b. City, Town, or Location of Death<br><b>Chesley</b>                                                                                                                                                                                                                        |  | 4c. County of Death<br><b>Prince George's</b>                                                                                                                                                                                                           |  |
| 5. Social Security Number<br><b>500-24-5604</b>                                                                                                                                                                                          |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                   |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.                                                                                                                                                                                                                              |  | 8. Date of Birth (Month, Day, Year)<br><b>May 14, 1928</b>                                                                                                                                                                                              |  |
| 9. Birthplace (State or Foreign Country)<br><b>Missouri</b>                                                                                                                                                                              |  | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10b. County<br><b>Prince George's</b>                                                                                                                                                                                                                                         |  | 10c. City, Town or Location<br><b>Forestville</b>                                                                                                                                                                                                       |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                           |  | 10e. Street and Number<br><b>1657 Tulip Avenue</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 10f. Zip Code<br><b>20747</b>                                                                                                                                                                                                                                                 |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                                                                          |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                           |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                            |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                 |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                 |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b>                                                                                                                                 |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administrator</b>                                                                                                                                                                                                                                                                                            |  | 16b. Kind of Business/Industry<br><b>Government</b>                                                                                                                                                                                                                           |  | 17. Father's Name (First, Middle, Last)<br><b>Benjamin Vernon Williams Sr</b>                                                                                                                                                                           |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Luprenia Catherine Holiday</b>                                                                                                                                                   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jerome B. Williams -son</b>                                                                                                                                                                                                                                                                                                                                           |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1657 Tulip Avenue Forestville MD 20747</b>                                                                                                                                |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b> |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resurrection Cemetery</b>                                                                                                                                   |  | 20c. Date<br><b>6-28-00</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 20d. Location - City or Town, State<br><b>Clinton Maryland</b>                                                                                                                                                                                                                |  | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                           |  |
| 22. Name and Address of Facility<br><b>J.B. Jenkins Funeral Home</b>                                                                                                                                                                     |  | 22. Name and Address of Facility<br><b>7474 Landover RD Landover MD 20785</b>                                                                                                                                                                                                                                                                                                                                                |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Subdural Hematoma</b>                                         |  | Approximate Interval Between Onset and Death<br><b>3 months</b>                                                                                                                                                                                         |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Fractured Ribs with hemorrhage<br/>multiple decubitus ulcers<br/>encephalopathy due to head injury</b> |  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                             |  | 23d. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                         |  | 23e. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                 |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                        |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                  |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month/Day/Year)<br><b>MARCH 28, 2000</b>                                                                                                                                                                                           |  |
| 28b. Time of Injury<br><b>5:00 PM</b>                                                                                                                                                                                                    |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                  |  | 28d. Describe how injury occurred<br><b>Slipped, struck head &amp; chest</b>                                                                                                                                                                                                  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>HOME</b>                                                                                                                                                   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1657 Tulip Avenue Forestville, Maryland 20747</b>                                                                                                     |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                     |  | 29c. License number<br><b>001852</b>                                                                                                                                                                                                                    |  |
| 29d. Date signed (Month, Day, Year)<br><b>JUNE 22 2000</b>                                                                                                                                                                               |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PAUL A. DEVORE MD 42031 Queensbury Rd Hyattsville MD 20781</b>                                                                                                                                                                                                                                                                    |  | 31. Date filed (Month, Day, Year)<br><b>JUN 27 2000</b>                                                                                                                                                                                                                       |  | 32. Registrar's Signature<br>                                                                                                                                                                                                                           |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. Did tobacco use contribute to the cause of death?  
☐ Yes ☐ No ☐ Probably ☒ Unknown

23d. Was an autopsy performed?  
☐ Yes ☒ No

23e. Were autopsy findings available prior to completion of cause of death?  
☐ Yes ☐ No

25. Was case referred to medical examiner?  
☒ Yes ☐ No

26. Place of Death (Check only one)  
Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death  
☐ Natural ☐ Pending Investigation  
☒ Accident ☐ Suicide ☐ Homicide  
☐ Could not be determined

28a. Date of Injury (Month/Day/Year)  
**MARCH 28, 2000**

28b. Time of Injury  
**5:00 PM**

28c. Injury at Work?  
☐ Yes ☒ No

28d. Describe how injury occurred  
**Slipped, struck head & chest**

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
**HOME**

28f. Location (Street and Number or Rural Route Number, City or Town, State)  
**1657 Tulip Avenue Forestville, Maryland 20747**

29a. Certifier (Check only one)  
☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

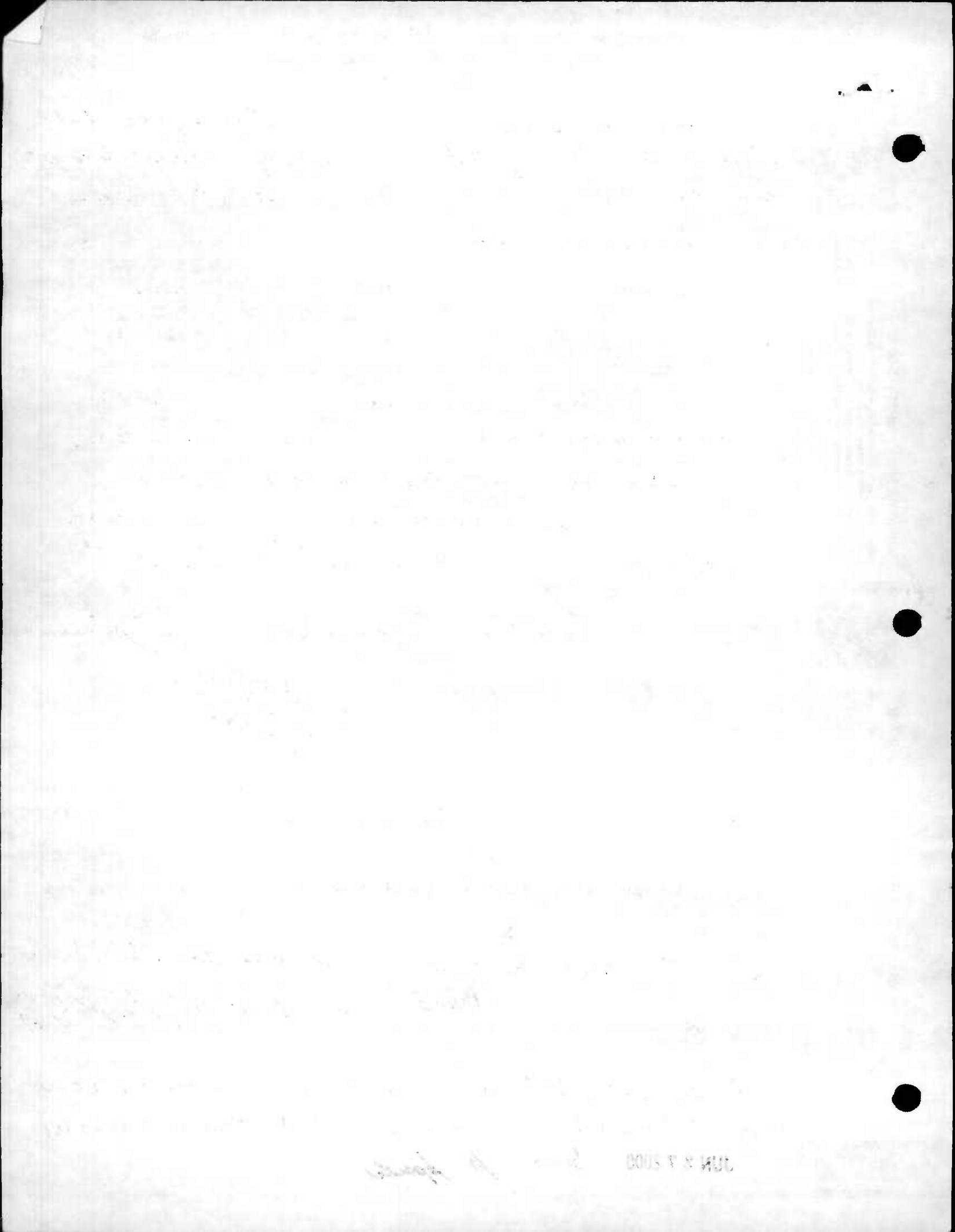
29c. License number  
**001852**

29d. Date signed (Month, Day, Year)  
**JUNE 22 2000**

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
**PAUL A. DEVORE MD 42031 Queensbury Rd Hyattsville MD 20781**

31. Date filed (Month, Day, Year)  
**JUN 27 2000**

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 23a,27 per me G785 7/14/00 yg

Certificate of Death

Reg. No.

00 22329

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WAYNE ANTONIO WRIGHT

2. Date of Death

Month Day Year  
JULY 4 2000

3. Time of Death

18:30 PM

4a. Facility Name (If not institution, give street and number)

2920 OXON PARK STREET

4b. City, Town, or Location of Death

TEMPLE HILLS

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director

5. Social Security Number

218 98 6948

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

33

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year  
July 25, 1966

9. Birthplace (State or Foreign Country)

Sumter, S.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Temple Hills

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2920 Oxon Park Street

10f. Zip Code

20748

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Patient Transporter

16b. Kind of Business/Industry

Private Hospital

17. Father's Name (First, Middle, Last)

James C. Wright

18. Mother's Name (First, Middle, Maiden Surname)

Hallie Q. Kennedy

19a. Informant's Name/Relationship (Type, Print)

James C. Wright/father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2920 Oxon Park Street Temple Hills, MD 20748

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Washington National Cem 7-10

Date

20c. Location - City or Town, State

Suitland, MD

21. Signature of Funeral Service Licensee

*James C. Buscoe Tonic*

22. Name and Address of Facility

Marshall's Funeral Home of MD  
4308 Suitland Road Suitland, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

SEIZURE DISORDER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a. b. c. d.

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) SCENE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*J. M. Titus*

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 5, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACK M. TITUS, M.D. 111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 10 2000

32. Registrar's Signature

*[Signature]*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22330

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                |                                                                                                                                                                                              |                                                                                                       |                                                                                                |                                                                                                                                         |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Alethea Christine Wheeler</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                | 2. Date of Death<br>Month Day Year<br><b>July 5, 2000</b>                                                                                                                                    |                                                                                                       | 3. Time of Death<br><b>11:15 PM</b>                                                            |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not Institution, give street and number)<br><b>2707 Openshaw Rd.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                | 4b. City, Town, or Location of Death<br><b>White Hall</b>                                                                                                                                    |                                                                                                       | 4c. County of Death<br><b>Baltimore</b>                                                        |                                                                                                                                         |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>212-20-8010</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.                                                                                                  | If Under 1 Year<br>Months Days                                                                                                 | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br><b>May 29, 1923</b>                                            |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                |                                                                                                                                                                                              |                                                                                                       |                                                                                                |                                                                                                                                         |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 10b. County<br><b>Baltimore</b>                                                                                                                                                                                                                                                             |                                                                                                                                                   | 10c. City, Town or Location<br><b>White Hall</b>                                                                               |                                                                                                                                                                                              |                                                                                                       | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>2707 Openshaw Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 10f. Zip Code<br><b>21161</b>                                                                                                  |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                        |                                                                                                |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                       | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bookkeeper</b> |                                                                                                                                                                                              |                                                                                                       | 16b. Kind of Business/Industry<br><b>Propane Supplier</b>                                      |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. Father's Name (First, Middle, Last)<br><b>Earl S. Riley, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Loretta (Unknown)</b>                                                                                                                |                                                                                                       |                                                                                                |                                                                                                                                         |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                             | 19a. Informant's Name/Relationship (Type, Print)<br><b>Nancy C. Brokaw/Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>413 Darby Lane, Bel Air, MD 21015</b>                                                    |                                                                                                       |                                                                                                |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>West Liberty Cemetery</b>                                            |                                                                                                                                | Date<br><b>July 10, 2000</b>                                                                                                                                                                 |                                                                                                       | 20c. Location - City or Town, State<br><b>White Hall, MD</b>                                   |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                | 22. Name and Address of Facility<br><b>J.J. Hartenstein Mortuary, Inc.<br/>24 Second St., New Freedom, PA 17349</b>                                                                          |                                                                                                       |                                                                                                |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Cardio Pulmonary Failure</b><br>Due to (or as a consequence of):<br>b. <b>Small Occipital Infarct</b><br>Due to (or as a consequence of):<br>c. <b>Hypertensive Arteriosclerotic Cardio Vascular Disease</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                |                                                                                                                                                                                              |                                                                                                       |                                                                                                |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                |                                                                                                                                                                                              |                                                                                                       |                                                                                                |                                                                                                                                         |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><b>Dementia</b><br><br><b>Diabetis Mellitus</b><br><br><b>Cerebral Atrophy</b>                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                |                                                                                                                                                                                              | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                                                                                                                |                                                                                                                                                                                              |                                                                                                       |                                                                                                |                                                                                                                                         |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>                                                                                                |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                      |                                                                                                | 28d. Describe how injury occurred                                                                                                       |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                   |                                                                                                                                                   | 29c. License number<br><b>D-09383</b>                                                                                          |                                                                                                                                                                                              | 29d. Date signed (Month, Day, Year)<br><b>July 6, 2000</b>                                            |                                                                                                |                                                                                                                                         |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Charles F. O'Donnell MD 1301 Home Hill Rd Baltimore Md 21210</b>                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                |                                                                                                                                                                                              |                                                                                                       |                                                                                                |                                                                                                                                         |
| 31. Date filed (Month, Day, Year)<br><b>JUL 13 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |                                                                                                                                                   |                                                                                                                                |                                                                                                                                                                                              |                                                                                                       |                                                                                                |                                                                                                                                         |

Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22331  
Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                           |                                                                                                                |                                                            |                                                                                                                                                    |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>RICHARD LARRIMER WHITTINGTON</b>                        |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 2. Date of Death<br>Month Day Year<br><b>June 21 2000</b> |                                                                                                                | 3. Time of Death<br><b>7:25 PM</b>                         |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis ElderCare - The Pines</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4b. City, Town, or Location of Death<br><b>Easton</b>     |                                                                                                                | 4c. County of Death<br><b>Talbot</b>                       |                                                                                                                                                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>215-12-6385</b>                                                        |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.          |                                                                                                                | 8. Date of Birth (Month, Day, Year)<br><b>May 23, 1923</b> |                                                                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                            |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>Maryland</b>                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 10b. County<br><b>Talbot</b>                              |                                                                                                                | 10c. City, Town or Location<br><b>St. Michaels</b>         |                                                                                                                                                    |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                              |                                                                            | 10e. Street and Number<br><b>215 Madison Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                           | 10f. Zip Code<br><b>21663</b>                                                                                  |                                                            | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                     |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b><br>If Yes, Give Year or Dates <b>U.S. Navy</b>                                                                                                               |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                        |                                                            |                                                                                                                                                    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b><br>College (1-4 or 5+)                                                                                                                                                                                                                                                                                           |                                                                                                        | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Printer</b>                                                                                                                                                                 |                                                                            | 16b. Kind of Business/Industry<br><b>Waverly Press</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                           | 17. Father's Name (First, Middle, Last)<br><b>John L. Whittington</b>                                          |                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Alma Louise Larrimer</b>                                                                   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Shelley S. Mielke Daughter</b>                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>26273 Daffin Rd. Easton, Maryland 21601</b>                                                                                                                                             |                                                                            | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                |                                                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Olivet Cemetery June 24, 2000</b> |                                                            | 20c. Location - City or Town, State<br><b>St. Michaels, Maryland</b>                                                                               |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                           |                                                                                                        | 22. Name and Address of Facility<br><b>Harrison E. Leonard Funeral Home<br/>312 S. Talbot St. St. Michaels, Maryland 21663</b>                                                                                                                                                              |                                                                            | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic bladder cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |                                                           | Approximate Interval Between Onset and Death<br><b>Months</b>                                                  |                                                            |                                                                                                                                                    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                           | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No          |                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                        | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                           |                                                           | 28a. Date of Injury (Month, Day, Year)                                                                         |                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                    |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                                        | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                   |                                                            |                                                                                                                                                    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                        | 29b. Signature and title of certifier<br> MD                                                                                                                                                             |                                                                            | 29c. License number<br><b>D25750</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                           | 29d. Date signed (Month, Day, Year)<br><b>6/22/00</b>                                                          |                                                            |                                                                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ROBERT SANCHEZ, MD 508 IDLEWILD AVENUE EASTON, MD 21601</b>                                                                                                                                                                                                                                                                    |                                                                                                        | 31. Date filed (Month, Day, Year)<br><b>JUN 26 2000</b>                                                                                                                                                                                                                                     |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                           |                                                                                                                |                                                            |                                                                                                                                                    |  |

Richard Whittington  
Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

00 22332

## Certificate of Death

Reg. No.

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><b>EMILY LEE WELCH</b>                                     |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>June 28 2000</b>               |                                                                                                                                                                                                  |                                                       | 3. Time of Death<br><b>11:15 PM</b>                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis ElderCare - The Pines</b> |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Easton</b>                   |                                                                                                                                                                                                  |                                                       | 4c. County of Death<br><b>Talbot</b>                           |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><b>220-32-1356</b>                                                        |                                                                                                                                                   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs. |                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 14, 1908</b>             |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                            |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                              |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        | 10b. County<br><b>TALBOT</b>                                                                                                                      |                                                                            | 10c. City, Town or Location<br><b>EASTON</b>                                                                                                                                                                                                                                                |                                                  |                                                                                                                                              |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |                                                       |                                                                |  |
| 10e. Street and Number<br><b>16 N. AURORA ST.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                   |                                                                            | 10f. Zip Code<br><b>21601</b>                                                                                                                                                                                                                                                               |                                                  |                                                                                                                                              | 10g. Citizen of What Country?<br><b>USA</b>                             |                                                                                                                                                                                                  |                                                       |                                                                |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                |                                                  |                                                                                                                                              | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |                                                                                                                                                                                                  |                                                       |                                                                |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>5</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                   |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                                                                                                                                                               |                                                  |                                                                                                                                              | 16b. Kind of Business/Industry<br><b>OWN HOME</b>                       |                                                                                                                                                                                                  |                                                       |                                                                |  |
| 17. Father's Name (First, Middle, Last)<br><b>DR. PHILIP LEE TRAVERS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MAUDE EMILY MACHALE</b>                                                              |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MARRIOTT W. MOSZKA/DAUGHTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>36 WINDSOR RD. SANDWICH, MASS. 02563</b> |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                   |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE CREMATION CTR. 6-29-00</b>                                                                                                                                                                          |                                                  | 20c. Location - City or Town, State<br><b>STEVENSVILLE, MD</b>                                                                               |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> <b>CFSP</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                   |                                                                            | 22. Name and Address of Facility<br><b>FELLOWS, HELFENBEIN &amp; NEWMAN FUNERAL HOME, PA<br/>200 S. HARRISON ST. EASTON, MD 21601</b>                                                                                                                                                       |                                                  |                                                                                                                                              |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>b. COPD with Chronic Asthma, Bronchitis 10+ yrs</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>ASHD with Congestive Heart Failure</b> |                                                                                                        |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                              |                                                                         |                                                                                                                                                                                                  |                                                       | Approximate Interval Between Onset and Death<br><b>1 month</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ASHD with Congestive Heart Failure</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                              |                                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                       |                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                              |                                                                         | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                       |                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                              |                                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                       |                                                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                   |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                  |                                                                                                                                              |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                   |                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                  | 28b. Time of Injury<br><b>M</b>                                                                                                              |                                                                         | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                 |                                                       |                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                   |                                                                            | 28d. Describe how Injury occurred                                                                                                                                                                                                                                                           |                                                  |                                                                                                                                              |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                   |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                  |                                                                                                                                              |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                   |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                  |                                                                                                                                              |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                   |                                                                            | 29b. Signature and title of certifier<br><b>William H. Wood Jr. MD</b>                                                                                                                                                                                                                      |                                                  |                                                                                                                                              |                                                                         | 29c. License number<br><b>208715</b>                                                                                                                                                             |                                                       |                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                   |                                                                            | 29d. Date signed (Month, Day, Year)<br><b>6/29/00</b>                                                                                                                                                                                                                                       |                                                  |                                                                                                                                              |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William Wood, MD 505 DUTCHMAN'S LANE EASTON, MD 21601</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                             |                                                  |                                                                                                                                              |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                |  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 29 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                        |                                                                                                                                                   |                                                                            | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                             |                                                  |                                                                                                                                              |                                                                         |                                                                                                                                                                                                  |                                                       |                                                                |  |

Emily Welch

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-692-2029.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22333

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                                                                                                          |                                                        |                                                                                                                                                        |                                                       |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br>Catherine Ellen Walker                     |                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                                                                                                          | 2. Date of Death<br>Month Day Year<br>June 28, 2000    |                                                                                                                                                        | 3. Time of Death<br>9:15PM                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br>11203 Cranford Drive |                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                                                                                                          | 4b. City, Town, or Location of Death<br>Upper Marlboro |                                                                                                                                                        | 4c. County of Death<br>Prince George's Co.            |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br>213-40-4620                                               |                                                                                                                                                                                                                                                                                                                 | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br>Yrs. 59              |                                                                                                                                                        | 8. Date of Birth (Month, Day, Year)<br>March 27, 1941 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Maryland                                   |                                                                                                                                                                                                                                                                                                                 | 10a. State<br>MD                                                               |                                                                                                                                                                                                          | 10b. County<br>Prince George's Co.                     |                                                                                                                                                        | 10c. City, Town or Location<br>Upper Marlboro         |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                 |                                                                                        | 10e. Street and Number<br>11203 Cranford Drive                                                                                                                                                                                                                                                                  |                                                                                | 10f. Zip Code<br>20772                                                                                                                                                                                   |                                                        | 10g. Citizen of What Country?<br>U.S.A.                                                                                                                |                                                       |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                             |                                                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                           |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |                                                        | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                       |                                                       |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) College                                                                                                                                                                                                                                                                                                                   |                                                                                        | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                                                                                                                                          |                                                                                | 16b. Kind of Business/Industry<br>Home                                                                                                                                                                   |                                                        |                                                                                                                                                        |                                                       |  |
| 17. Father's Name (First, Middle, Last)<br>Simon Thomas Kenny                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                                                                                                                                                                                                                                                                                 |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ellen Fallon Murray                                                                                                                                 |                                                        |                                                                                                                                                        |                                                       |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Albert A. Walker (Husband)                                                                                                                                                                                                                                                                                                                                                                     |                                                                                        |                                                                                                                                                                                                                                                                                                                 |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11203 Cranford Dr. Upper Marlboro, MD 20772                                                             |                                                        |                                                                                                                                                        |                                                       |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                    |                                                                                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Rose Hill Cemetery                                                                                                                                                                                                                    |                                                                                | 20c. Location - City or Town, State<br>July 3, 2000 Hagerstown, MD                                                                                                                                       |                                                        |                                                                                                                                                        |                                                       |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                                                                                                                                                                                                                                                                                 |                                                                                | 22. Name and Address of Facility<br>Lee Funeral Home Calvert, P.A.<br>8125 Southern Maryland Blvd. Owings, MD 20736                                                                                      |                                                        |                                                                                                                                                        |                                                       |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                        | e. <u>HEPATIC ENCEPHALOPATHY</u><br>Due to (or as a consequence of):<br>b. <u>CIRRHOSIS OF LIVER</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Approximate Interval Between Onset and Death                                                                        |                                                                                |                                                                                                                                                                                                          |                                                        |                                                                                                                                                        |                                                       |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                             |                                                                                        |                                                                                                                                                                                                                                                                                                                 |                                                                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                        |                                                                                                                                                        |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                                                                                                                                                                                                                 |                                                                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                        | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                       |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                              |                                                                                        | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)         |                                                                                |                                                                                                                                                                                                          |                                                        |                                                                                                                                                        |                                                       |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                             |                                                                                        | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                          |                                                                                | 28b. Time of Injury<br>M                                                                                                                                                                                 |                                                        | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                   |                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                          |                                                                                | 28d. Describe how injury occurred                                                                                                                                                                        |                                                        | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                           |                                                       |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner                                                                                                                                                                                                                                                                                                                                                          |                                                                                        | 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                |                                                                                                                                                                                                          |                                                        |                                                                                                                                                        |                                                       |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                        | 29c. License number<br>D 46478                                                                                                                                                                                                                                                                                  |                                                                                | 29d. Date signed (Month, Day, Year)<br>6/29/00                                                                                                                                                           |                                                        |                                                                                                                                                        |                                                       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Suresh Patel M.D. 7501 Surratts Road Suite 302 Clinton, Maryland 20735                                                                                                                                                                                                                                                                                     |                                                                                        |                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                                                                                                          |                                                        |                                                                                                                                                        |                                                       |  |
| 31. Date filed (Month, Day, Year)<br>JUN 30 2000                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                        | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                   |                                                                                |                                                                                                                                                                                                          |                                                        |                                                                                                                                                        |                                                       |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

20

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22334

## Certificate of Death

Reg. No.

|                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                               |                                                                             |                                                                                  |                                                                         |                                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Anna Wallech</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   | 2. Date of Death<br>Month <b>July</b> Day <b>2</b> Year <b>2000</b>                                                           |                                                                                                                                                                                               |                                                                             | 3. Time of Death<br><b>08:18</b>                                                 |                                                                         |                                                                                                |  |
|                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br><b>The Johns Hopkins Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                   | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>                                                                 |                                                                                                                                                                                               |                                                                             | 4c. County of Death<br><b>Baltimore</b>                                          |                                                                         |                                                                                                |  |
| Funeral<br>Director                                                                                                                                | 5. Social Security Number<br><b>215-14-2174</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.                                                                                                                                              |                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 24, 1916</b>                      |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>                                |  |
|                                                                                                                                                    | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                               |                                                                             |                                                                                  |                                                                         |                                                                                                |  |
| To Be Completed by Funeral Director                                                                                                                | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. County<br><b>Washington</b>                                                                                                                  |                                                                                                                               | 10c. City, Town or Location<br><b>Hagerstown</b>                                                                                                                                              |                                                                             |                                                                                  |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|                                                                                                                                                    | 10e. Street and Number<br><b>544 George Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |                                                                                                                               | 10f. Zip Code<br><b>21740</b>                                                                                                                                                                 |                                                                             | 10g. Citizen of What Country?<br><b>USA</b>                                      |                                                                         |                                                                                                |  |
|                                                                                                                                                    | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                             |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                |  |
|                                                                                                                                                    | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>homemaker</b> |                                                                                                                                                                                               |                                                                             | 16b. Kind of Business/Industry<br><b>home</b>                                    |                                                                         |                                                                                                |  |
|                                                                                                                                                    | 17. Father's Name (First, Middle, Last)<br><b>Frederick Willard Poper</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Edna Ida Lohman</b> |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                    | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary A. Ricker Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                   |                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>319 Ridge Avenue Hagerstown, Maryland 21740</b>                                           |                                                                             |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                    | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Leitersburg Cemetery</b>                         |                                                                                                                                                                                               |                                                                             | 20c. Location - City or Town, State<br><b>7/6/00 Leitersburg, Maryland</b>       |                                                                         |                                                                                                |  |
|                                                                                                                                                    | 21. Signature of Funeral Service Licensee<br><b>Gerald N. Minnich</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   | 22. Name and Address of Facility<br><b>Gerald N. Minnich 305 N. Potomac Street Hagerstown, Maryland 21740</b>                 |                                                                                                                                                                                               |                                                                             |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                               |                                                                             |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                    | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                               |                                                                             |                                                                                  |                                                                         |                                                                                                |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                               |                                                                             |                                                                                  |                                                                         |                                                                                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                               |                                                                             |                                                                                  |                                                                         |                                                                                                |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner                                                                               | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                               |                                                                             |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                    | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                               |                                                                             |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                    | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                               |  | 28a. Date of Injury (Month, Day Year)                                                                                                             |                                                                                                                               | 28b. Time of Injury<br>M                                                                                                                                                                      |                                                                             | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                         | 28d. Describe how injury occurred                                                              |  |
|                                                                                                                                                    | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |                                                                                                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                  |                                                                             |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                    | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                             |  |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                               |                                                                             |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                    | 29b. Signature and title of certifier<br><b>J. Schreiber, MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |                                                                                                                               | 29c. License number<br><b>RES-600</b>                                                                                                                                                         |                                                                             |                                                                                  | 29d. Date signed (Month, Day, Year)<br><b>July 2, 2000</b>              |                                                                                                |  |
|                                                                                                                                                    | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jose Schreiber 600 North Wolfe St. Baltimore MD 21207</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                               |                                                                             |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                    | 31. Date filed (Month, Day, Year)<br><b>JUL 05 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                     |                                                                                                                               |                                                                                                                                                                                               |                                                                             |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                    | State Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |                                                                                                                               |                                                                                                                                                                                               |                                                                             |                                                                                  |                                                                         |                                                                                                |  |



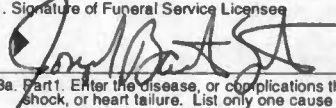
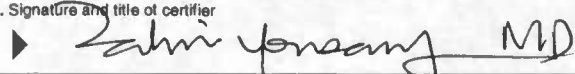
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22335

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                          |                                     |                                                                                                                                                       |                                            |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                 |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|-----------------------------|------------------------------------------------------------------------|----|-------------------------------------|----|--|----|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br>Agatha Gwendolyn Walter                      |                                     |                                                                                                                                                       |                                            |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br>July 03, 2000 |                                                                                                 | 3. Time of Death<br>10:04AM                                                                        |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br>Civista Medical Center |                                     |                                                                                                                                                       |                                            |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>La Plata    |                                                                                                 | 4c. County of Death<br>Charles                                                                     |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br>214-76-3690                                                 |                                     | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                            | 7. Age (In yrs. last birthday)<br>77 Yrs.                                                                                                                                                                                                                                                               |                                                     | 8. Date of Birth (Month, Day, Year)<br>July 25, 1922                                            |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Maryland |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Usual Residence of Decedent                                                              |                                     |                                                                                                                                                       |                                            |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                 |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                          | 10b. County<br>Charles              |                                                                                                                                                       | 10c. City, Town or Location<br>Hughesville |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                 | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| 10e. Street and Number<br>13987 Burnt Store Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                          |                                     |                                                                                                                                                       |                                            | 10f. Zip Code<br>20637                                                                                                                                                                                                                                                                                  |                                                     | 10g. Citizen of What Country?<br>U. S. A.                                                       |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                          |                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                       |                                                     |                                                                                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collega (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                          |                                     |                                                                                                                                                       |                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                                                                                                                                  |                                                     |                                                                                                 | 16b. Kind of Business/Industry<br>At Home                                                          |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| 17. Father's Name (First, Middle, Last)<br>Samuel Cleveland Cooksey                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          |                                     |                                                                                                                                                       |                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br>Florence Madeline Murphy                                                                                                                                                                                                                           |                                                     |                                                                                                 |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Robert Mark Walter/Son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                          |                                     |                                                                                                                                                       |                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5415 Sandy Pt. Rd. Prince Frederick, MD 20678                                                                                                                                                          |                                                     |                                                                                                 |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                          |                                     | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Mary's Church Cem.                                                      |                                            | Date<br>July 7, 2000                                                                                                                                                                                                                                                                                    |                                                     | 20c. Location - City or Town, State<br>Bryantown, Maryland                                      |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| 21. Signature of Funeral Service Licensee<br> M00641                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                          |                                     |                                                                                                                                                       |                                            | 22. Name and Address of Facility<br>Brinsfield-Echols Funeral Home, PA<br>30195 Three Notch Rd. Charlotte Hall, MD 20622                                                                                                                                                                                |                                                     |                                                                                                 |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                          |                                     |                                                                                                                                                       |                                            |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                 |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>Acute Myocardial infarction</td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/>           Hx. of acute onset         </td> </tr> <tr> <td>b.</td> <td>Hypertensive Cardiovascular disease</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |                                                                                          |                                     |                                                                                                                                                       |                                            |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                 |                                                                                                    |                                                      | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | Acute Myocardial infarction | Approximate Interval Between Onset and Death<br><br>Hx. of acute onset | b. | Hypertensive Cardiovascular disease | c. |  | d. |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                                                                                                                                                                  | a.                                                                                       | Acute Myocardial infarction         | Approximate Interval Between Onset and Death<br><br>Hx. of acute onset                                                                                |                                            |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                 |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | b.                                                                                       | Hypertensive Cardiovascular disease |                                                                                                                                                       |                                            |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                 |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | c.                                                                                       |                                     |                                                                                                                                                       |                                            |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                 |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | d.                                                                                       |                                     |                                                                                                                                                       |                                            |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                 |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Respiratory insufficiency Chronic, Pulmonary Fibrosis, Sjogren Syndrome, Chronic Renal failure                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                          |                                     |                                                                                                                                                       |                                            |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                 |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                          |                                     |                                                                                                                                                       |                                            | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                     |                                                                                                 |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                             |                                                                                          |                                     | 28a. Date of Injury (Month, Day, Year)                                                                                                                |                                            | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                                |                                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                    | 28d. Describe how injury occurred                    |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                   |                                                                                          |                                     |                                                                                                                                                       |                                            | 29b. Signature and title of certifier<br> MD                                                                                                                                                                         |                                                     |                                                                                                 |                                                                                                    |                                                      | 29c. License number<br>D-27189                                                                                                                                                                                                    |    |                             |                                                                        |    |                                     |    |  |    |  |
| 29d. Date signed (Month, Day, Year)<br>7/3/00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                          |                                     |                                                                                                                                                       |                                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Zahir Yousaf, MD Cenna Center 7-Y Post Office Road Waldorf, Maryland 20602                                                                                                                                      |                                                     |                                                                                                 |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |
| 31. Date filed (Month, Day, Year)<br>JUL 05 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                          |                                     |                                                                                                                                                       |                                            | 32. Registrar's Signature<br>                                                                                                                                                                                       |                                                     |                                                                                                 |                                                                                                    |                                                      |                                                                                                                                                                                                                                   |    |                             |                                                                        |    |                                     |    |  |    |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





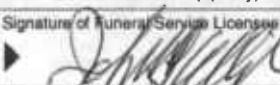
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22336

## Certificate of Death

Reg. No.

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                               |                                                                                                |                                                                                             |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>KATHRYN CREECH WARD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                | 2. Date of Death<br>Month Day Year<br><b>June 26, 2000</b>                                                                                                                                    |                                                                                                | 3. Time of Death<br><b>0843</b>                                                             |
|                                                                      | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>                                                                                                                                      |                                                                                                | 4c. County of Death<br><b>WICOMICO</b>                                                      |
| Funeral<br>Director                                                  | 5. Social Security Number<br><b>579-24-6171</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                        | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.                                                                                                                                                                                                                                            | If Under 1 Year<br>Months Days                                                                                                                 | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                | 8. Date of Birth (Month, Day, Year)<br><b>11-22-23</b>                                         | 9. Birthplace (State or Foreign Country)<br><b>D.C.</b>                                     |
|                                                                      | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                               |                                                                                                |                                                                                             |
| To Be Completed by Funeral Director                                  | 10e. State<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 10b. County<br><b>WORCESTER</b>                                                                                   | 10c. City, Town or Location<br><b>OCEAN PINES</b>                                                                                                                                                                                                                                           |                                                                                                                                                |                                                                                                                                                                                               | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                             |
|                                                                      | 10e. Street and Number<br><b>15 DOGWOOD PLACE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   |                                                                                                                                                                                                                                                                                             | 10f. Zip Code<br><b>21811</b>                                                                                                                  |                                                                                                                                                                                               | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                 |                                                                                             |
|                                                                      | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |
|                                                                      | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOMEMAKER</b>                                                                                                                                                               |                                                                                                                                                | 16b. Kind of Business/Industry<br><b>OWN HOME</b>                                                                                                                                             |                                                                                                |                                                                                             |
|                                                                      | 17. Father's Name (First, Middle, Last)<br><b>FULTON HUNTER CREECH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                   |                                                                                                                                                                                                                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>PAULINE MCKAY BRYAN</b>                                                                |                                                                                                                                                                                               |                                                                                                |                                                                                             |
| Physician<br>/Medical<br>Examiner                                    | 19e. Informant's Name/Relationship (Type, Print)<br><b>PHYLLIS C. KOCH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   |                                                                                                                                                                                                                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9207 TOWN GATE RD. BETHESDA, MD. 20817</b> |                                                                                                                                                                                               |                                                                                                |                                                                                             |
|                                                                      | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SALISBURY CREMATORY</b>                                                                                                                                                                                        |                                                                                                                                                | 20c. Location - City or Town, State<br><b>6-26 SALISBURY, MD.</b>                                                                                                                             |                                                                                                |                                                                                             |
|                                                                      | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                   |                                                                                                                                                                                                                                                                                             | 22. Name and Address of Facility<br><b>ULLRICH FUNERAL HOME BERLIN, MD. 21811</b>                                                              |                                                                                                                                                                                               |                                                                                                |                                                                                             |
|                                                                      | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>5 days</b> |                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                               |                                                                                                |                                                                                             |
|                                                                      | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>COPD</b><br><b>Peripheral Vascular Disease</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                               |                                                                                                |                                                                                             |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                       |                                                                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                            |                                                                                                |                                                                                             |
|                                                                      | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                |                                                                                                                                                                                               |                                                                                                |                                                                                             |
|                                                                      | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                   | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|                                                                      | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                                                                                                                |                                                                                                                                                                                               |                                                                                                |                                                                                             |
|                                                                      | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                             |                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                               |                                                                                                |                                                                                             |
| State Registrar                                                      | 29b. Signature and title of certifier<br><b>J. Steve Julian MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   | 29c. License number<br><b>D41813</b>                                                                                                                                                                                                                                                        |                                                                                                                                                | 29d. Date signed (Month, Day, Year)<br><b>6/26/00</b>                                                                                                                                         |                                                                                                |                                                                                             |
|                                                                      | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. Steve Julian MD 201 Pine Bluff Rd Salisbury MD 21801</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                               |                                                                                                |                                                                                             |
| 31. Date filed (Month, Day, Year)<br><b>JUN 26 2000</b>              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 32. Registrar's Signature<br> |                                                                                                                                                                                                                                                                                             |                                                                                                                                                |                                                                                                                                                                                               |                                                                                                |                                                                                             |

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



ADH  
UNKNOWN 00-182  
00-3775-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEM: 1, PER MEO G787 9-29-00 WR  
State of Maryland Department of Health and Mental Hygiene  
AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO G787 9-29-00 WR.  
WANDA MURRAY JEAN ALMONY

00 22337

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
303A.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME

Division of Vital Records, P.O. Box 68760,

|                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br>Wanda Jean Almony                                                                                                                                                                                                                                                    |  | 2. Date of Death<br>Month Day Year<br>JULY 9, 2000                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 3. Time of Death<br>1825 PM                                                                                                                                                                       |  |
| 4a. Facility Name (If not institution, give street and number)<br>304 S. NORRIS STREET                                                                                                                                                                                                                           |  | 4b. City, Town, or Location of Death<br>BALTIMORE CITY                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4c. County of Death<br>N/A                                                                                                                                                                        |  |
| 5. Social Security Number<br>220-64-5305                                                                                                                                                                                                                                                                         |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                             |  | 7. Age (In yrs. last birthday)<br>43 Yrs.                                                                                                                                                         |  |
| 8. Date of Birth (Month, Day, Year)<br>Jan. 27, 1957                                                                                                                                                                                                                                                             |  | 9. Birthplace (State or Foreign Country)<br>WV                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                 |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                 |  | 10b. County<br>N/A                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10c. City, Town or Location<br>Baltimore                                                                                                                                                          |  |
| 10e. Street and Number<br>1903 Harman Avenue                                                                                                                                                                                                                                                                     |  | 10f. Zip Code<br>21230                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 10g. Citizen of What Country?<br>United States                                                                                                                                                    |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                           |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                                                                                      |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                                                                                                                                 |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0                                                                                                                                                                                                                                                                                                                                                                    |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Packer                                                                               |  |
| 16b. Kind of Business/Industry<br>Manufacturing                                                                                                                                                                                                                                                                  |  | 17. Father's Name (First, Middle, Last)<br>Harvey Franklin Murray                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ellouise Ann Humphreys                                                                                                                       |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Deborah J. White / Sister                                                                                                                                                                                                                                    |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Route 4, Box 440 B Martinsburgh WV 25401                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                   |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Green Mount Cemetery                                                                                                                                                                                                                                                                                                                                                                                             |  | 20c. Location - City or Town, State<br>Baltimore Maryland                                                                                                                                         |  |
| 20d. Date<br>July 14, 2000                                                                                                                                                                                                                                                                                       |  | 21. Signature of Funeral Service Licensee<br>Victor P. Doda, Jr.<br>Charles L. Stevens Funeral Home, Inc.<br>1501 East Fort Avenue, Baltimore Maryland 21230                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                   |  |
| 22. Name and Address of Facility                                                                                                                                                                                                                                                                                 |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>ACUTE NARCOTIC INTOXICATION<br>Due to (or as a consequence of):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                   |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                         |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                           |  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) AT SCENE |  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined                                                                                                                                                                                                        |  |                                                                                                                                                                                                   |  |
| 28a. Date of Injury (Month, Day, Year)<br>7-9-00                                                                                                                                                                                                                                                                 |  | 28b. Time of Injury<br>6:20 PM                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                   |  |
| 28d. Describe how injury occurred<br>UNKNOWN                                                                                                                                                                                                                                                                     |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>FOUND IN VACANT DWELLING                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>304 S. NORRIS ST. BALTIMORE, MARYLAND                                                                                                                                                                                            |  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                              |  |                                                                                                                                                                                                   |  |
| 29b. Signature and title of certifier<br>Dennis J. Chute MD                                                                                                                                                                                                                                                      |  | 29c. License number<br>OCME                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 29d. Date signed (Month, Day, Year)<br>JULY 10, 2000                                                                                                                                              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                 |  | 32. Registrar's Signature<br>Benjamin Sparks                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                   |  |

PROCESS 100

100-100-100

100-100-100

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State of Maryland / Department of Health and Mental Hygiene

AMENDED ITEM #20b PER FH G785 7/14/00 AH

## Certificate of Death

Reg. No.

00 22338

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JULIUS JUNIOR ATKINS

2. Date of Death  
Month Day Year

July 10, 2000

3. Time of Death

8:43AM

4a. Facility Name (If not Institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-26-8980

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

JAN. 12, 1930

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1712 HARTSDALE ROAD

10f. Zip Code

21239

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
5<sup>TH</sup> GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

CAR PAINTER

16b. Kind of Business/Industry

AISQUITZ AUTO SERVICE

17. Father's Name (First, Middle, Last)

JAMES

18. Mother's Name (First, Middle, Maiden Surname)

CARTER VIOLA ATKINS

19a. Informant's Name/Relationship (Type, Print)

YVONNE ATKINS (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1712 HARTSDALE ROAD, BALTIMORE, MD. 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE NATIONAL

Date

7-17-00

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

J. Brown

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME  
3140 N. FULTON AVE. BALTO. MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward Seidel MD

29c. License number

D38956

29d. Date signed (Month, Day, Year)

July 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward Seidel MD, 5601 Loch Raven Blvd, Baltimore MD 21239-2995

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

Benjamin B Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

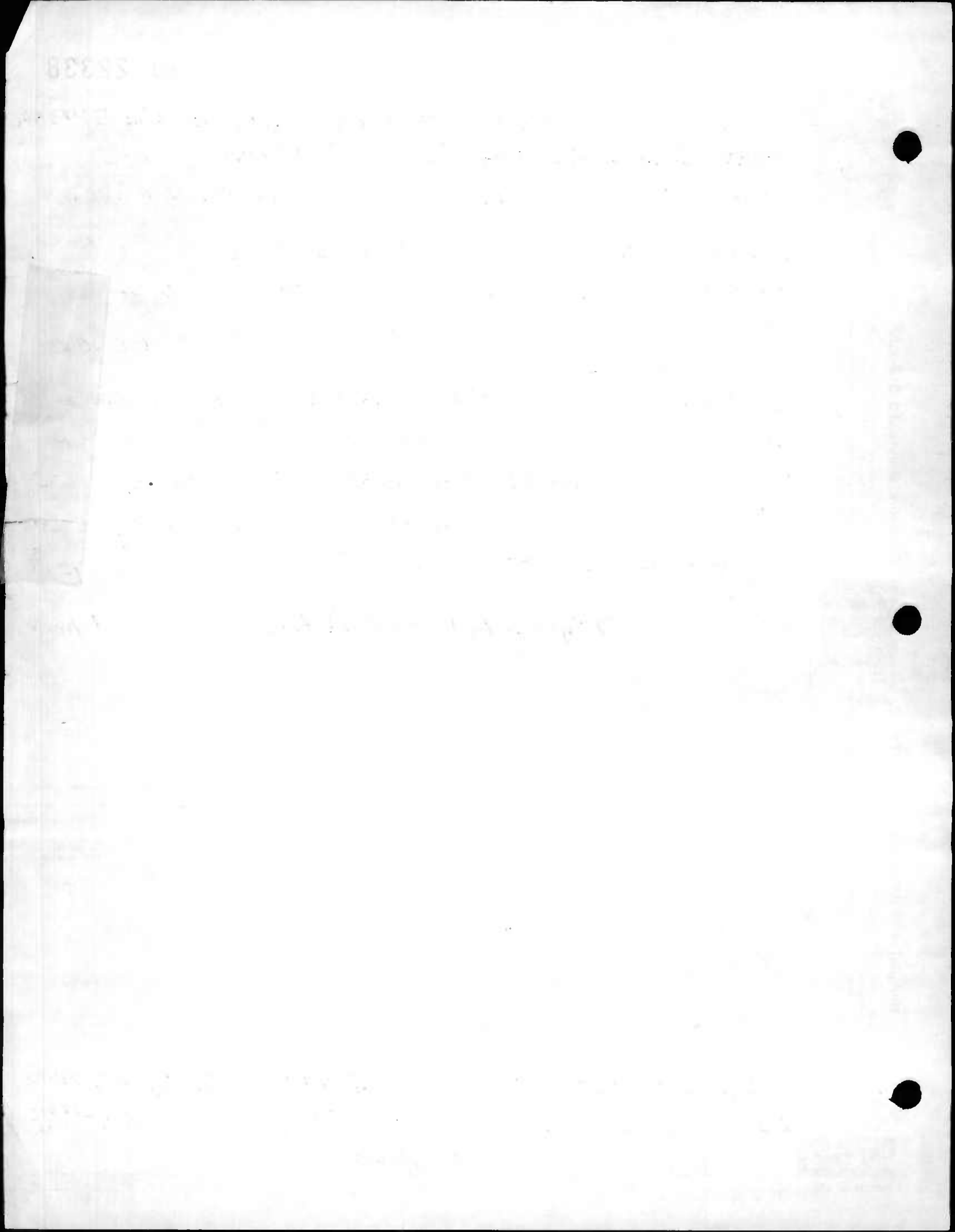
Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



000000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22339

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

RAYMOND

ARAN

2. Date of Death

Month

Day

Year

July 11, 2000

3. Time of Death

04:50 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

213-94-1695

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

21

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 2, 1978

9. Birthplace (State or Foreign Country)

Puerto Rico

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Severn

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1357 Jamestown Drive

10f. Zip Code

21144

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Jose A. Aran, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Sandra Figueroa

19a. Informant's Name/Relationship (Type, Print)

Jose A. Aran, Jr. (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1357 Jamestown Drive, Severn, MD 21144

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Epiphany Episcopal Cem.

Date

07/15

2000

20c. Location - City or Town, State

Odenton, MD

21. Signature of Funeral Service Licensee

Bartek J. Gubel

22. Name and Address of Facility

Hardesty Funeral Home, P.A.

12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

RESPIRATORY FAILURE

Approximate Interval Between Onset and Death

18 DAYS

Due to (or as a consequence of):

NEURODEGENERATIVE DISEASE

21 YEARS

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

REACTIVE AIRWAY DISEASE

SEVERE MENTAL RETARDATION

GASTROESOPHAGEAL REFLUX

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

B. M.D.

29c. License number

D0055336

29d. Date signed (Month, Day, Year)

07/11/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FOLASADE O. OGUNLESI, M.D., DEPT. OF PED. PULMONARY, 600 N. WOLFE STR. JHMI, PARK 316

BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

B. Sparks

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

RECEIVED

00 22340

## Certificate of Death

Reg. No.

DHHM 16 Rev 6/95

04833

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph document, possibly a report or a letter, with several lines of text visible across the page. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22341

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CHARLOTTE BARROW

2. Date of Death

Month

Day

Year

07

06

00

3. Time of Death

22 55

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

042-341-7421

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
7/6/17

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

NY

10b. County

Erie

10c. City, Town or Location

West Seneca

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

725 Main Street

10f. Zip Code

14224

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life, DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Perry W. Barrett

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Mae Brown

19a. Informant's Name/Relationship (Type, Print)

Joyce Barrow / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3930 Brian Court, Hamburg, NY 14075

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

D. Tonkin Corporation

Date

July 11, 2000

20c. Location - City or Town, State

Tonawanda, NY

21. Signature of Funeral Service Licensee Victor P. Doda, Jr.

[Signature]

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.  
1501 East Fort Avenue, Baltimore Maryland 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. PULMONARY FAILURE

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. SEPSIS

Due to (or as a consequence of):

c. ESOPHAGEAL PERFORATION

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

2 ☒ Inpatient3 ☐ ER/Outpatient4 ☐ DOA

Other:

5 ☐ Nursing Home6 ☐ Residence7 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

250590

29d. Date signed (Month, Day, Year)

7/6/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONATHAN CALVERT M.D. 22 S. Green St. Bkto. MD 21230

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22342

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |                                                                                                                                              |                                                                                                                                                                                                     |                                                                                                                                                                                                          |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|-----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|-----------------|-------|----|-------------------------|--------|----|--|--|----|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br><b>John Kenneth Bare</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |                                                                                                                                              | 2. Date of Death<br>Month Day Year<br>Jul 12, 2000                                                                                                                                                  |                                                                                                                                                                                                          | 3. Time of Death<br>2:10 p.m.                                    |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br>9929 Evergreen Ave                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |                                                                                                                                              | 4b. City, Town, or Location of Death<br>Columbia                                                                                                                                                    |                                                                                                                                                                                                          | 4c. County of Death<br>Howard                                    |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br>216-22-9153                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input type="checkbox"/> F<br>X                                                                                                                                                                                                                                | 7. Age (In yrs. last birthday)<br>74 Yrs.                                                                                                  | If Under 1 Year<br>Months Days                                                                                                               | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                      | 8. Date of Birth (Month, Day, Year)<br>Apr 9, 1926                                                                                                                                                       | 9. Birthplace (State or Foreign Country)<br>MD                   |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |                                                                                                                                              |                                                                                                                                                                                                     |                                                                                                                                                                                                          |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                              | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10b. County<br>Howard                                                                                                                                                                                                                                                                                   | 10c. City, Town or Location<br>Columbia                                                                                                    |                                                                                                                                              |                                                                                                                                                                                                     | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10e. Street and Number<br>9929 Evergreen Ave                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            | 10f. Zip Code<br>21046                                                                                                                       |                                                                                                                                                                                                     | 10g. Citizen of What Country?<br>U.S.A.                                                                                                                                                                  |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                              | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                          | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Truck Driver                  |                                                                                                                                              | 16b. Kind of Business/Industry<br>Trucking                                                                                                                                                          |                                                                                                                                                                                                          |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. Father's Name (First, Middle, Last)<br>Samuel D. Bare                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |                                                                                                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br>Hattie Young                                                                                                                                   |                                                                                                                                                                                                          |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                    | 19a. Informant's Name/Relationship (Type, Print)<br>Ms. Clara Jo Bare                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9929 Evergreen Ave Columbia, Maryland 21046 |                                                                                                                                                                                                     |                                                                                                                                                                                                          |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>All County Cremation Services, Inc.                              |                                                                                                                                              | Date<br>07/14/00                                                                                                                                                                                    |                                                                                                                                                                                                          | 20c. Location - City or Town, State<br>Sykesville, Maryland      |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. Signature of Funeral Service Licensee<br><i>Timothy S. Hannon</i> MD1113                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            | 22. Name and Address of Facility<br>Slack Funeral Home, P.A.<br>3871 Old Columbia Pike Ellicott City, MD 21043                               |                                                                                                                                                                                                     |                                                                                                                                                                                                          |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |                                                                                                                                              |                                                                                                                                                                                                     |                                                                                                                                                                                                          |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | <table border="1"> <tr> <td rowspan="4">           Immediata Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>cancer cachexia</td> <td>weeks</td> </tr> <tr> <td>b.</td> <td>metastatic colon cancer</td> <td>months</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |                                                                                                                                              |                                                                                                                                                                                                     |                                                                                                                                                                                                          |                                                                  |                                   | Immediata Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | cancer cachexia | weeks | b. | metastatic colon cancer | months | c. |  |  | d. |  |
| Immediata Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                | a.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | cancer cachexia                                                                                                                                                                                                                                                                                         | weeks                                                                                                                                      |                                                                                                                                              |                                                                                                                                                                                                     |                                                                                                                                                                                                          |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | b.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | metastatic colon cancer                                                                                                                                                                                                                                                                                 | months                                                                                                                                     |                                                                                                                                              |                                                                                                                                                                                                     |                                                                                                                                                                                                          |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | c.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |                                                                                                                                              |                                                                                                                                                                                                     |                                                                                                                                                                                                          |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | d.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |                                                                                                                                              |                                                                                                                                                                                                     |                                                                                                                                                                                                          |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |                                                                                                                                              |                                                                                                                                                                                                     | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |                                                                                                                                              |                                                                                                                                                                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                            |                                                                                                                                              |                                                                                                                                                                                                     |                                                                                                                                                                                                          |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                            | 28b. Time of Injury<br>M                                                                                                                     |                                                                                                                                                                                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                                                                  | 28d. Describe how injury occurred |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 29b. Signature and title of certifier<br><i>John A. Singer M.D.</i>                                                                                                                                                                                                                                     |                                                                                                                                            | 29c. License number<br>D18092                                                                                                                |                                                                                                                                                                                                     | 29d. Date signed (Month, Day, Year)<br>7/13/00                                                                                                                                                           |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Singer St. Agnes Hospital 900 S. Caton Ave Balto, MD 21230                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                            |                                                                                                                                              |                                                                                                                                                                                                     |                                                                                                                                                                                                          |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 32. Registrar's Signature<br><i>Beverly B. Sparks</i>                                                                                                                                                                                                                                                   |                                                                                                                                            |                                                                                                                                              |                                                                                                                                                                                                     |                                                                                                                                                                                                          |                                                                  |                                   |                                                                                                                                                                                                                                   |    |                 |       |    |                         |        |    |  |  |    |  |

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State of Maryland / Department of Health and Mental Hygiene 00 22343

## Certificate of Death

Reg. No.

|                                                                                                                                                                                |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                      |                                                                                                                                                    |                                                             |                                                                             |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                              | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT E. BOCK SR</b>                         |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2. Date of Death<br>Month <b>JULY</b> Day <b>12</b> Year <b>2000</b> |                                                                                                                                                    | 3. Time of Death<br><b>9:20 am</b>                          |                                                                             |  |
|                                                                                                                                                                                | 4a. Facility Name (If not institution, give street and number)<br><b>1523 Florida Avenue</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4b. City, Town, or Location of Death<br><b>Severn</b>                |                                                                                                                                                    | 4c. County of Death<br><b>Anne Arundel</b>                  |                                                                             |  |
| Funeral<br>Director                                                                                                                                                            | 5. Social Security Number<br><b>214-56-1608</b>                                              |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.                     |                                                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 12, 1953</b> |                                                                             |  |
|                                                                                                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                  |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>MD</b>                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10b. County<br><b>Anne Arundel</b>                                   |                                                                                                                                                    | 10c. City, Town or Location<br><b>Severn</b>                |                                                                             |  |
| Usual Residence of Decedent                                                                                                                                                    |                                                                                              | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                              |                                                                            | 10e. Street and Number<br><b>1523 Florida Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                      | 10f. Zip Code<br><b>21144</b>                                                                                                                      |                                                             | 10g. Citizen of What Country?<br><b>USA</b>                                 |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |                                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                            |                                                             |                                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b></b>                                            |                                                                                              | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mechanic</b>                                                                                                                                                                |                                                                            | 16b. Kind of Business/Industry<br><b>Automobile</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                      | 17. Father's Name (First, Middle, Last)<br><b>Charles Edward Bock</b>                                                                              |                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Doris May Lilly</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Penny M. Wells (Friend)</b>                                                                                             |                                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1523 Florida Avenue, Severn, MD 21144</b>                                                                                                                                               |                                                                            | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>                                                   |                                                             | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>                 |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                  |                                                                                              | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Avenue, Annapolis, MD 21401</b>                                                                                                                                                                           |                                                                            | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Carcinoma of Lung</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                                                                      | Approximate Interval Between Onset and Death<br><b>3 1/2 mos.</b>                                                                                  |                                                             |                                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                         |                                                                                              | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |                                                                            | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                             |                                                                             |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                              |                                                                                              | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                |                                                                      | 28a. Date of Injury (Month, Day, Year)<br><b></b>                                                                                                  |                                                             | 28b. Time of Injury<br><b>M</b>                                             |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                               |                                                                                              | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                      | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                       |                                                             |                                                                             |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner                                                                                        |                                                                                              | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                   |                                                                            | 29c. License number<br><b>031557</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                      | 29d. Date signed (Month, Day, Year)<br><b>July 13, 2000</b>                                                                                        |                                                             |                                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Russell R. Delmonico 1600 S. Craig Highway, Gaithersburg, Md. 20878</b>             |                                                                                              | 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                     |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                      |                                                                                                                                                    |                                                             |                                                                             |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

6

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



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State of Maryland / Department of Health and Mental Hygiene  
00 22344  
6783 7-31-00 WR.

Judy Lynn Bowles

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                         |                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                    |                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>Judy Lynn Bowles</b>                                                     |                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month <b>July</b> Day <b>06</b> Year <b>2000</b> |                                                                                                                                                    | 3. Time of Death<br><b>05:40 A.M.</b>                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>Train track @ Nebel Street &amp; Randolph Road</b> |                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Rockville</b>             |                                                                                                                                                    | 4c. County of Death<br><b>Montgomery</b>                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>138-68-1453</b>                                                                         |                                                                                                                                                                                                                                                                                                          | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>31</b> Yrs.                     |                                                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br><b>June 16, 1969</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>                                                        |                                                                                                                                                                                                                                                                                                          | 10a. State<br><b>Md.</b>                                                   |                                                                                                                                                                                              | 10b. County<br><b>Montgomery</b>                                     |                                                                                                                                                    | 10c. City, Town or Location<br><b>Silver Springs</b>        |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                                                         | 10e. Street and Number<br><b>3935 Lantern Lane</b>                                                                                                                                                                                                                                                       |                                                                            | 10f. Zip Code<br><b>20902</b>                                                                                                                                                                |                                                                      | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                     |                                                             |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                        |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                            |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4 + 1</b>                                                                                                                                                                                                                                                                                    |                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Computer Analyst</b>                                                                                                                                                                     |                                                                            | 16b. Kind of Business/Industry<br><b>Market Research</b>                                                                                                                                     |                                                                      |                                                                                                                                                    |                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>Alvin Otis Bowles, Jr.</b>                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                         |                                                                                                                                                                                                                                                                                                          |                                                                            | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Patricia Ann Shinnars</b>                                                                                                              |                                                                      |                                                                                                                                                    |                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Alvin O. Bowles, Jr. - Father</b>                                                                                                                                                                                                                                                                                                                                     |                                                                                                                         |                                                                                                                                                                                                                                                                                                          |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4114 Walnut Pond Drive, Houston, Texas 77059</b>                                         |                                                                      |                                                                                                                                                    |                                                             |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory July 14, 2000</b>                                                                                                                                                                                           |                                                                            | 20c. Location - City or Town, State<br><b>Baltimore, Md.</b>                                                                                                                                 |                                                                      |                                                                                                                                                    |                                                             |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                         | 22. Name and Address of Facility<br><b>Eckhardt Funeral Chapel</b><br><b>11605 Reisterstown Rd., Owings Mills, Md.</b>                                                                                                                                                                                   |                                                                            | 22. Name and Address of Facility<br><b>21117</b>                                                                                                                                             |                                                                      |                                                                                                                                                    |                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>MULTIPLE INJURIES</b><br><br>a. Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):        |                                                                                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                              |                                                                            | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                        |                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |                                                                                                                         |                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                    |                                                             |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                         | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b> |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                    |                                                             |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined                                                                                                                                                      |                                                                                                                         | 28a. Date of Injury (Month, Day, Year)<br><b>7-6-00</b>                                                                                                                                                                                                                                                  |                                                                            | 28b. Time of Injury<br><b>5:50</b> M                                                                                                                                                         |                                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                        |                                                             |  |
| 28d. Describe how injury occurred<br><b>SUBJECT STRUCK BY TRAIN</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                         | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>TRAIN TRACKS</b>                                                                                                                                                                                            |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>RANDOLPH RD. &amp; NEBEL STREET, ROCKVILLE, MD.</b>                                                       |                                                                      |                                                                                                                                                    |                                                             |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                         | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                |                                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                       |                                                                      | 29d. Date signed (Month, Day, Year)<br><b>July 7, 2000</b>                                                                                         |                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING</b>                                                                                                                                                                                                                                                                                                              |                                                                                                                         | 31. Date filed (Month, Day, Year)<br><b>JUL 31 2000</b>                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                    |                                                             |  |
| 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                         | 33. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                    |                                                             |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar



July 1967

June 16, 1967

11

156-1-102

Subject

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State of Maryland / Department of Health and Mental Hygiene 00 22345

## Certificate of Death

Reg. No.

|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                            |  |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                      |                                                                  |                                                                                                    |  |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                            | 1. Decedent's Name (First, Middle, Last)<br>Russell Martin Boykin                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                            |  |                                                                                                                                                                                                   | 2. Date of Death<br>Month Day Year<br>July 11, 2000                                                                                                                                                                                                                                                     |                                                                                      | 3. Time of Death<br>3:31 PM                                      |                                                                                                    |  |
|                                                                              | 4a. Facility Name (If not institution, give street and number)<br>Johns Hopkins Bayview Medical Ctr.                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                            |  |                                                                                                                                                                                                   | 4b. City, Town, or Location of Death<br>Baltimore City                                                                                                                                                                                                                                                  |                                                                                      | 4c. County of Death<br>N/A                                       |                                                                                                    |  |
| Funeral<br>Director                                                          | 5. Social Security Number<br>215-16-0963                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                 |  | 7. Age (In yrs. last birthday)<br>Yrs. 77                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         | 8. Date of Birth (Month, Day, Year)<br>May 27, 1923                                  |                                                                  | 9. Birthplace (State or Foreign Country)<br>Maryland                                               |  |
|                                                                              | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                            |  |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Funeral Director                                          | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. County<br>Baltimore                                                                                                                                   |  | 10c. City, Town or Location<br>Dundalk                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                      |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|                                                                              | 10e. Street and Number<br>2100 Cameron Drive Apt. 1 A                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                            |  | 10f. Zip Code<br>21222                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         | 10g. Citizen of What Country?<br>United States                                       |                                                                  |                                                                                                    |  |
|                                                                              | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                         |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                                                                                                                         |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                    |  |
|                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4 Years<br>College (1-4 or 5+) _____                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                            |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Painter                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                                      | 16b. Kind of Business/Industry<br>Home Improvement               |                                                                                                    |  |
|                                                                              | 17. Father's Name (First, Middle, Last)<br>Charles Boykin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                            |  |                                                                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Gossman                                                                                                                                                                                                                                       |                                                                                      |                                                                  |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner                                | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Bessie Barker (Sister)                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                            |  |                                                                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2100 Cameron Drive Apt. 1A Dundalk, MD 21222                                                                                                                                                           |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                              | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Crownsville V.A. Cem.                                                            |  | Date<br>7/14/00                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         | 20c. Location - City or Town, State<br>Crownsville, MD                               |                                                                  |                                                                                                    |  |
|                                                                              | 21. Signature of Funeral Service Licenses<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                            |  |                                                                                                                                                                                                   | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave. Dundalk, Maryland 21222                                                                                                                                                                                   |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                              | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Acute Myocardial infarction<br>Due to (or as a consequence of):<br>b. Atherosclerosis<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Approximate Interval Between Onset and Death<br>30 min<br>> 10 yrs |  |                                                                                                                                                            |  |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>hx hypertension, hx smoking, increased cholesterol, Diabetes, Emphysema                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                            |  |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                      |                                                                  |                                                                                                    |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                            |  |                                                                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                              | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                      |  | 28a. Date of Injury (Month, Day Year)                                                                                                                      |  | 28b. Time of Injury<br>M                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                  |  |
|                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                     |  |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                                                  |                                                                                                    |  |
|                                                                              | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                               |  |                                                                                                                                                            |  |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                              | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                            |  |                                                                                                                                                                                                   | 29c. License number<br>D36430                                                                                                                                                                                                                                                                           |                                                                                      | 29d. Date signed (Month, Day, Year)<br>7/12/00                   |                                                                                                    |  |
| State Registrar                                                              | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Betsey Richardson, MD 2112 Dundalk, Baltimore 21222                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                            |  |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                      |                                                                  |                                                                                                    |  |
|                                                                              | 31. Date filed (Month, Day, Year)<br>JUL 14, 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 32. Registrar's Signature<br>                                                                                                                              |  |                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                      |                                                                  |                                                                                                    |  |

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State of Maryland / Department of Health and Mental Hygiene 00 22346

## Certificate of Death

Reg. No.

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|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Robert Albert Barnhart                                                                                                                                                                                                                     |  |                                                                                                                                                       |  | 2. Date of Death<br>Month Day Year<br>July 8 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 3. Time of Death<br>0420                                                                                                                                                                                                                                                                                                                                                                                                         |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>Washington County Hospital                                                                                                                                                                                           |  |                                                                                                                                                       |  | 4b. City, Town, or Location of Death<br>Hagerstown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 4c. County of Death<br>Washington                                                                                                                                                                                                                                                                                                                                                                                                |  |
| Funeral<br>Director                           | 5. Social Security Number<br>164-34-1577                                                                                                                                                                                                                                               |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br>60 Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 8. Date of Birth (Month, Day, Year)<br>September 23, 1939                                                                                                                                                                                                                                                                                                                                                                        |  |
|                                               | 9. Birthplace (State or Foreign Country)<br>PA                                                                                                                                                                                                                                         |  | 10a. State<br>PA                                                                                                                                      |  | 10b. County<br>Fulton                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 10c. City, Town or Location<br>Warfordsburg                                                                                                                                                                                                                                                                                                                                                                                      |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                     |  | 10e. Street and Number<br>908 Big Cove Road                                                                                                           |  | 10f. Zip Code<br>17267                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10g. Citizen of What Country?<br>USA                                                                                                                                                                                                                                                                                                                                                                                             |  |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                 |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                      |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                                                                                                                                                                                                                                                 |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (14 or 5+)                                                                                                                                                                |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Inspector                                |  | 16b. Kind of Business/Industry<br>State Government                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 17. Father's Name (First, Middle, Last)<br>Albert Barnhart                                                                                                                                                                                                                                                                                                                                                                       |  |
|                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Evelyn Faith                                                                                                                                                                                                                      |  | 19a. Informant's Name/Relationship (Type, Print)<br>Barbara J. Barnhart/Wife                                                                          |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>908 Big Cove Road Warfordsburg, PA 17267                                                                                                                                                                                                                                                                                                                                                                                             |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |  |
| Physician<br>/Medical<br>Examiner             | 21. Signature of Funeral Service Licensee                                                                                                                                                                                                                                              |  | 22. Name and Address of Facility<br>Grove Funeral Home, P.A.<br>141 W. Main St. Hancock, MD 21750-0368                                                |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>a. ACUTE MYELOGENOUS LEUKEMIA<br>Due to (or as a consequence of)<br>b. CHRONIC MYELOGENOUS LEUKEMIA<br>Due to (or as a consequence of)<br>c. DIABETES MELLITUS<br>Due to (or as a consequence of)<br>d. CHRONIC ATRIAL FIBRILLATION<br>Approximate Interval Between Onset and Death<br>YEARS<br>WEEKS<br>YEARS<br>YEARS- |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                         |  |
|                                               | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                              |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No           |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                |  | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                             |  |
|                                               | 28d. Describe how injury occurred                                                                                                                                                                                                                                                      |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| State Registrar                               | 29b. Signature and Title of Certifier                                                                                                                                                                                                                                                  |  | 29c. License number<br>D22043                                                                                                                         |  | 29d. Date signed (Month, Day, Year)<br>7/8/00.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>LINDA MEDICAL CAMPUS RN #130 HAGERSTOWN, MD                                                                                                                                                                                                                                                                                              |  |
|                                               | 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                       |  | 32. Registrar's Signature<br>Benjamin B. Sparks                                                                                                       |  | 33. Date of Death (Month, Day, Year)<br>JUL 8 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 34. Time of Death<br>0420                                                                                                                                                                                                                                                                                                                                                                                                        |  |

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## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                             |                                |                                                                                             |                                                                  |                                                                                                                                                                                                             |                                                                                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Frank L. Cordier, Sr.                     |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br>JULY 08 2000                                                                                                                                           |                                                                                                                                             |                                |                                                                                             | 3. Time of Death<br>1705                                         |                                                                                                                                                                                                             |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>ST ALMES HEALTHCARE |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br>BALTIMORE                                                                                                                                            |                                                                                                                                             |                                |                                                                                             | 4c. County of Death                                              |                                                                                                                                                                                                             |                                                                                                |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>074-18-8426                                              |                          | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br>74 Yrs.                                                                                                                                                    |                                                                                                                                             | If Under 1 Year<br>Months Days |                                                                                             | 8. Date of Birth (Month, Day, Year)<br>Aug. 6, 1925              |                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br>New York                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                           |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                             |                                |                                                                                             |                                                                  |                                                                                                                                                                                                             | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                       | 10b. County<br>Baltimore |                                                                                                                                                   | 10c. City, Town or Location<br>Catonsville                                                                                                                                                                                                                                                  |                                                                                                                                                                                              |                                                                                                                                             |                                | 10g. Citizen of What Country?<br>USA                                                        |                                                                  |                                                                                                                                                                                                             |                                                                                                |  |
| 10e. Street and Number<br>I-E MacIntosh Court                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                       |                          |                                                                                                                                                   | 10f. Zip Code<br>21228                                                                                                                                                                                                                                                                      |                                                                                                                                                                                              |                                                                                                                                             |                                | 10g. Citizen of What Country?<br>USA                                                        |                                                                  |                                                                                                                                                                                                             |                                                                                                |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                             |                                |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                                                                                                                             |                                                                                                |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                       |                          |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Maintenance                                                                                                                                                                    |                                                                                                                                                                                              |                                                                                                                                             |                                | 16b. Kind of Business/Industry<br>Manufacturing                                             |                                                                  |                                                                                                                                                                                                             |                                                                                                |  |
| 17. Father's Name (First, Middle, Last)<br>Charles Cordier                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                       |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br>Alfreda Loether                                                                        |                                |                                                                                             |                                                                  |                                                                                                                                                                                                             |                                                                                                |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Frank L. Cordier, Jr./Son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                       |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3 hillside Drive, Lake City, Florida 32025 |                                |                                                                                             |                                                                  |                                                                                                                                                                                                             |                                                                                                |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                          |                                                                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Meadowridge Memorial Prk                                                                                                                                                                                          |                                                                                                                                                                                              | Date<br>7/12/00                                                                                                                             |                                | 20c. Location - City or Town, State<br>Elkridge, Maryland                                   |                                                                  |                                                                                                                                                                                                             |                                                                                                |  |
| 21. Signature of Funeral Service Licensee<br>Hilda L. Lemmer 1100741                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                          |                                                                                                                                                   | 22. Name and Address of Facility<br>Witzke Funeral Homes, Inc.<br>1630 Edmondson Avenue, Catonsville, MD 21228                                                                                                                                                                              |                                                                                                                                                                                              |                                                                                                                                             |                                |                                                                                             |                                                                  |                                                                                                                                                                                                             |                                                                                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. MULTIPLE SYSTEM ORGAN FAILURE<br>Due to (or as a consequence of):<br>b. SEPSIS<br>Due to (or as a consequence of):<br>c. PNEUMONIA<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                       |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                             |                                |                                                                                             |                                                                  | Approximate Interval Between Onset and Death<br>9 HOURS<br>3 DAYS<br>4 DAYS                                                                                                                                 |                                                                                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                       |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                             |                                |                                                                                             |                                                                  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                             |                                |                                                                                             |                                                                  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                       |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                             |                                |                                                                                             |                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                          |                                                                                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                          |                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                              |                                                                                                                                             |                                |                                                                                             |                                                                  |                                                                                                                                                                                                             |                                                                                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                    |                                                                                       |                          |                                                                                                                                                   | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                                                                                              | 28b. Time of Injury<br>M                                                                                                                    |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                                                                                                                           |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                          |                                                                                                                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                                                                                              |                                                                                                                                             |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |                                                                  |                                                                                                                                                                                                             |                                                                                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                     |                                                                                       |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                             |                                |                                                                                             |                                                                  |                                                                                                                                                                                                             |                                                                                                |  |
| 29b. Signature and title of certifier<br>Hilda L. Lemmer PGY 3                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                       |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              | 29c. License number<br>P12591                                                                                                               |                                |                                                                                             | 29d. Date signed (Month, Day, Year)<br>JULY 08 2000              |                                                                                                                                                                                                             |                                                                                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ROBERT GROOMER ST. ALMES HEALTHCARE 900 CATON AVE. BALTIMORE MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                       |                          |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                             |                                |                                                                                             |                                                                  |                                                                                                                                                                                                             |                                                                                                |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                       |                          |                                                                                                                                                   | 32. Registrar's Signature<br>Benjamin B. Sparks                                                                                                                                                                                                                                             |                                                                                                                                                                                              |                                                                                                                                             |                                |                                                                                             |                                                                  |                                                                                                                                                                                                             |                                                                                                |  |

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State of Maryland / Department of Health and Mental Hygiene

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## Certificate of Death

Reg. No.

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Adella Carver</b>                                       |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <b>July</b> Day <b>10</b> Year <b>2000</b>                                                                                  |                                                                                                                                                                                              | 3. Time of Death<br><b>7:25 PM</b>             |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>3004 North Ridge Rd. Apt. 329</b> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Ellicott City</b>                                                                                          |                                                                                                                                                                                              | 4c. County of Death<br><b>Howard County</b>    |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>217-07-5940</b>                                                        | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>95</b> Yrs.                                                                                                      | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 21, 1905</b>                                            |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                           |                                                                                                                                                                                              |                                                |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | 10b. County<br><b>Howard</b>                                                                                                                                                                                                                                                                |                                                                                                                                                       | 10c. City, Town or Location<br><b>Ellicott City</b>                                                                                                                                          |                                                |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| 10e. Street and Number<br><b>3004 North Ridge Road- Apt. 329</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                                                                                                                                                             | 10f. Zip Code<br><b>21043</b>                                                                                                                         |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>U.S.A.</b> |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                                                                                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>                                                                                                                                                                                                                                                                                      |                                                                                                        | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Administator</b>                                                                                                                                                            |                                                                                                                                                       | 16b. Kind of Business/Industry<br><b>Internal Revenue Service</b>                                                                                                                            |                                                |
| 17. Father's Name (First, Middle, Last)<br><b>Hervey G. Foutz</b>                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                                                                                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ella M. Bauer</b>                                                                             |                                                                                                                                                                                              |                                                |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Dorothy Folger- Sister</b>                                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                                                                                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2802 Evergreen Ave. Baltimore, Maryland 21214</b> |                                                                                                                                                                                              |                                                |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                                                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>                                                                                                                                                                                          |                                                                                                                                                       | 20c. Location - City or Town, State<br><b>7/14/00 Woodlawn, Maryland</b>                                                                                                                     |                                                |
| 21. Signature of Funeral Service Licensee<br><b>Heather Cain</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21214<br/>Leonard J. Ruck, Inc. 5305 Harford Rd.</b>                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| a. <b>DEMENTIA - progressive</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        | <b>7 YEARS</b>                                                                                                                                                                                                                                                                              |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| b. <b>MILD HYPERTENSION</b>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        | <b>7 YEARS</b>                                                                                                                                                                                                                                                                              |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| c. <b>AORTIC SCLEROSIS</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        | <b>7 YEARS</b>                                                                                                                                                                                                                                                                              |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| d.                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                   |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>OSTEOPOROSIS</b><br><b>COMPRESSION FRACTURES - SPINE</b>                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                        | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                             |                                                                                                        | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                                                       | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                                        | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                                                                                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| 29b. Signature and title of certifier<br><b>Dr. Ellis Seal</b>                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        | 29c. License number<br><b>025210</b>                                                                                                                                                                                                                                                        |                                                                                                                                                       | 29d. Date signed (Month, Day, Year)<br><b>July 10 / 2000</b>                                                                                                                                 |                                                |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ELICOTT CITY MARYLAND</b>                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                                                              |                                                |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                        | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                                                                                                                                                               |                                                                                                                                                       |                                                                                                                                                                                              |                                                |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

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## Certificate of Death

Reg. No.

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|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Judith L. Chilcote                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                         |  | 2. Date of Death<br>Month Day Year<br>July 9, 2000                                                                                                                                               |  | 3. Time of Death<br>10:55 AM                                                                                                                                                                              |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>Harford Memorial Hospital                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  | 4b. City, Town, or Location of Death<br>Havre De Grace                                                                                                                                           |  | 4c. County of Death<br>Harford County                                                                                                                                                                     |  |
| Funeral<br>Director                           | 5. Social Security Number<br>215-56-3365                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 7. Age (In yrs. last birthday)<br>48                                                                                                                                                             |  | 8. Date of Birth (Month, Day, Year)<br>Dec. 31, 1951                                                                                                                                                      |  |
|                                               | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                  |  | 10b. County<br>Baltimore                                                                                                                                                                         |  | 10c. City, Town or Location<br>Dundalk                                                                                                                                                                    |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 10e. Street and Number<br>7630 Dunmanway                                                                                                                                                                                                                                                                |  | 10f. Zip Code<br>21222                                                                                                                                                                           |  | 10g. Citizen of What Country?<br>United States                                                                                                                                                            |  |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                          |  |
| To Be Completed by Funeral Director           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 Years                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Proof Reader                                                                                                                                                                               |  | 16b. Kind of Business/Industry<br>Check Company                                                                                                                                                  |  |                                                                                                                                                                                                           |  |
|                                               | 17. Father's Name (First, Middle, Last)<br>Richard Dinges                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Beatrice Gill                                                                                                                               |  |                                                                                                                                                                                                           |  |
| To Be Completed by Funeral Director           | 19a. Informant's Name/Relationship (Type, Print) (Husband)<br>Mr. Robert M. Chilcote, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7630 Dunmanway Dundalk, Maryland 21222                                                          |  |                                                                                                                                                                                                           |  |
|                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dulaney Valley Mem. Gdn.                                                                                                                                                                                                      |  | Date<br>7/13/2000                                                                                                                                                                                |  | 20c. Location - City or Town, State<br>Timonium, MD                                                                                                                                                       |  |
| To Be Completed by Funeral Director           | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave. Dundalk, Maryland 21222                                                                            |  |                                                                                                                                                                                                           |  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>Cardiovascular Accident<br>Due to (or as a consequence of):<br>Atherosclerotic Cardiovascular disease<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b.<br>c.<br>d.<br>Approximate Interval Between Onset and Death<br>12 hours<br>5 years |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                           |  |
| Physician<br>/Medical<br>Examiner             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  | 23b. Did tobacco use contribute to the causes of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                 |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                           |  |
|                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                            |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. Time of Injury<br>M                                                                                                                                                                         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |  |                                                                                                                                                                                                           |  |
|                                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                           |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  | 29c. License number<br>H39022                                                                                                                                                                    |  | 29d. Date signed (Month, Day, Year)<br>July 10, 2000                                                                                                                                                      |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>VENER LOPEZ, DO MSCP 1308 Business Ctr Wy Edgewood MD 21040                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                           |  |
| State<br>Registrar                            | 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  | 32. Registrar's Signature<br>                                                                                                                                                                    |  |                                                                                                                                                                                                           |  |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                           |  |

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State of Maryland / Department of Health and Mental Hygiene

00 22350

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                         |                                                           |                                                                                                                                                    |                                                          |                                                                          |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>George Cascio</b>                                 |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br><b>July 07 2000</b> |                                                                                                                                                    | 3. Time of Death<br><b>9:00 a.m.</b>                     |                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |                                                                                                                                                    | 4c. County of Death<br><b>Baltimore</b>                  |                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>217-07-9789</b>                                                  |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.          |                                                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br><b>11/24/1918</b> |                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 9. Birthplace (State or Foreign Country)<br><b>Rockwood, PA</b>                                  |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>MD</b>                                                    |                                                                                                                                                                                                                                                                         | 10b. County<br><b>Baltimore</b>                           |                                                                                                                                                    | 10c. City, Town or Location<br><b>Baltimore</b>          |                                                                          |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                              |                                                                            | 10e. Street and Number<br><b>8 Featherstone Court</b>                                                                                                                                                                                                                   |                                                           | 10f. Zip Code<br><b>21236</b>                                                                                                                      |                                                          | 10g. Citizen of What Country?<br><b>U.S.A.</b>                           |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                            |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                            |                                                          |                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                     |                                                                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Corporate Executive</b>                                                                                                                                                     |                                                                            | 16b. Kind of Business/Industry<br><b>Martin Marietta Corp.</b>                                                                                                                                                                                                          |                                                           | 17. Father's Name (First, Middle, Last)<br><b>Gaetano Cascio</b>                                                                                   |                                                          | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Puglisi</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>George T. Cascio, Jr./Son</b>                                                                                                                                                                                                                                                                                                                                      |                                                                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7422 Longfield Drive Kingsville, MD 21087</b>                                                                                                                                           |                                                                            | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                   |                                                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cemetery</b>                                         |                                                          | 20c. Location - City or Town, State<br><b>7/10/00 Baltimore, MD</b>      |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  | 22. Name and Address of Facility<br><b>Lassahn Funeral Home, Inc.<br/>7401 Belair Road Baltimore, MD 21236</b>                                                                                                                                                                              |                                                                            | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Myocardial Infarction</b>                               |                                                           | Approximate Interval Between Onset and Death<br><b>2 hours</b>                                                                                     |                                                          |                                                                          |  |
| Immediate Cause (Final disease or condition resulting in death)<br><b>Myocardial Infarction</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                  | Due to (or as a consequence of):<br><b>Atheromatous coronary artery disease</b>                                                                                                                                                                                                             |                                                                            | Due to (or as a consequence of):                                                                                                                                                                                                                                        |                                                           | Due to (or as a consequence of):                                                                                                                   |                                                          | Due to (or as a consequence of):                                         |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                |                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                         |                                                           |                                                                                                                                                    |                                                          |                                                                          |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Usual Interstitial Pneumonia</b>                                                                                                                                                                                                                                                             |                                                                                                  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |                                                                            | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                   |                                                           | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                          |                                                                          |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |                                                           | 28a. Date of Injury (Month, Day, Year)                                                                                                             |                                                          | 28b. Time of Injury<br><b>M</b>                                          |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                                  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                  |                                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                       |                                                          |                                                                          |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                  | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                   |                                                                            | 29c. License number<br><b>D38403</b>                                                                                                                                                                                                                                    |                                                           | 29d. Date signed (Month, Day, Year)<br><b>7-7-00</b>                                                                                               |                                                          |                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Howard Steiner 5601 Loch Raven Blvd Balto 21239</b>                                                                                                                                                                                                                                                                            |                                                                                                  | 31. Data filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                     |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                                                                                           |                                                           |                                                                                                                                                    |                                                          |                                                                          |  |





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State of Maryland / Department of Health and Mental Hygiene

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## Certificate of Death

Reg. No.

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1. Decedent's Name (First, Middle, Last)<br>Jesse Geiss Davis                                   |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  | 2. Date of Death<br>Month Day Year<br>July 1, 2000 |                                                                                      |                                                     |                                                                                                    | 3. Time of Death<br>3:00am                           |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4a. Facility Name (If not institution, give street and number)<br>Lorien Nursing Home-Riverside |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br>Belcamp    |                                                                                      |                                                     |                                                                                                    | 4c. County of Death<br>Harford                       |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 5. Social Security Number<br>216-03-6281                                                        |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br>88 Yrs.          |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>Mar 17, 1912 |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Maryland |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Usual Residence of Decedent                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                     |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                 | 10b. County<br>Harford                                                                                                                                                                                                                                                                                  |                                                                                | 10c. City, Town or Location<br>Belcamp                                                                                                                                                           |                                                    |                                                                                      |                                                     | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                      |                                                                                                                                                                                                          |  |
| 10e. Street and Number<br>1123 Belcamp Garth                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                | 10f. Zip Code<br>21017                                                                                                                                                                           |                                                    | 10g. Citizen of What Country?<br>USA                                                 |                                                     |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                    |                                                                                      |                                                     | 14. Race - American Indian, Black, White, etc.<br>Specify:<br>White                                |                                                      |                                                                                                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Collega (1-4or 5+) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Sales Rep.                                                                          |                                                    |                                                                                      |                                                     | 16b. Kind of Business/Industry<br>Vending Com.                                                     |                                                      |                                                                                                                                                                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>Jesse B. Davis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Emma Geiss                                                                                                                                  |                                                    |                                                                                      |                                                     |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Phyllis Bordone                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>292 P Canterbury Rd., Bel Air, MD 21014                                                         |                                                    |                                                                                      |                                                     |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Evans Funeral Chapel-Bel Air                                                                                                                                                                                                  |                                                                                | Data<br>Jul 3 2000                                                                                                                                                                               |                                                    | 20c. Location - City or Town, State<br>Forest Hill, MD                               |                                                     |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                | 22. Name and Address of Facility<br>Evans Funeral Chapel<br>8800 Harford Rd. Parkville, MD                                                                                                       |                                                    |                                                                                      |                                                     |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Myocardial infarction</u><br>Due to (or as a consequence of):<br>b. <u>Acute renal failure</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>e.<br>Due to (or as a consequence of): |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                     |                                                                                                    |                                                      | Approximate Interval Between Onset and Death                                                                                                                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>chronic lymphocytic leukemia</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                     |                                                                                                    |                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                      |                                                    |                                                                                      |                                                     |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                 | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                     |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                    | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                     | 28d. Describe how injury occurred                                                                  |                                                      |                                                                                                                                                                                                          |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                    |                                                                                      |                                                     |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                        |                                                                                                 | 29b. Signature and title of certifier<br>                                                                                                                                                                            |                                                                                |                                                                                                                                                                                                  |                                                    | 29c. License number<br>027925                                                        |                                                     | 29d. Date signed (Month, Day, Year)<br>7/10/00                                                     |                                                      |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. David McClure 615 W. McPhail Rd. Bel Air, Md                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                     |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                 | 32. Registrar's Signature<br>                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                  |                                                    |                                                                                      |                                                     |                                                                                                    |                                                      |                                                                                                                                                                                                          |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

W-1

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND#8&amp;9 PER F.H. G785 7-25-2000 JAB

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22352

|                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                  |                                                                         |                                                                                                |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br><b>DAVID DENHAM</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  | 2. Date of Death<br>Month <b>July</b> Day <b>8th</b> Year <b>2000</b>            |                                                                         | 3. Time of Death<br><b>2:54 PM</b>                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                   | 4a. Facility Name (If not institution, give street and number)<br><b>Bayview Medical Center - Johns Hopkins</b>                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                         |                                                                         | 4c. County of Death<br><b>N/A</b>                                                              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                               | 5. Social Security Number<br><b>213-09-4028</b>                                                                                                                                                                                                                                                                                                                                                                           |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.                                                                                                                                             |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 15, 1915</b>                      |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA Maryland</b>                       |  |
|                                                                                                                                                                                                                                                                                                                                                   | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                  |                                                                         |                                                                                                |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                               | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. County<br><b>Baltimore</b>                                                                                                                   |  | 10c. City, Town or Location<br><b>Edgemere</b>                                                                                                                                               |  |                                                                                  |                                                                         | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                   | 10e. Street and Number<br><b>7723 North Cove Road</b>                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  | 10f. Zip Code<br><b>21219</b>                                                                                                                                                                |  | 10g. Citizen of What Country?<br><b>United States</b>                            |                                                                         |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Steelworker</b>                                                              |  |                                                                                  | 16b. Kind of Business/Industry<br><b>Steel Industry</b>                 |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 17. Father's Name (First, Middle, Last)<br><b>David E. Denham, Sr.</b>                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jane Rodgers Bell</b>    |                                                                         |                                                                                                |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Anna May Denham (Wife)</b>                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7723 North Cove Road Edgemere, Maryland 21219</b>                                        |  |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>                                                |  | Date<br><b>7/11/2000</b>                                                                                                                                                                     |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                |                                                                         |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 21. Signature of Funeral Service Licensee<br><i>Chad W. Ford</i>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>                                                                |  |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Anterior Myocardial Infarction.</b>                                                                                                                                                                       |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension</b><br><b>Diabetes.</b><br><b>Cerebrovascular Accidents.</b>                                                                                                                                                                                                               |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                  |                                                                         |                                                                                                |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                              | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                  |                                                                         |                                                                                                |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                |  | 28a. Date of Injury (Month, Day, Year)                                                                                                            |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                         | 28d. Describe how injury occurred                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 29b. Signature and title of certifier<br><b>Param Dedhia MD</b>                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                   |  | 29c. License number<br><b>20303</b>                                                                                                                                                          |  | 29d. Date signed (Month, Day, Year)<br><b>July 8th 2000</b>                      |                                                                         |                                                                                                |  |
| State Registrar                                                                                                                                                                                                                                                                                                                                   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Param Dedhia, M.D. 4940 Eastern Avenue Baltimore, Maryland 21224.</b>                                                                                                                                                                                                                                                          |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                                  |                                                                         |                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                   | 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  | 32. Registrar's Signature<br><i>Sparks</i>                                                                                                                                                   |  |                                                                                  |                                                                         |                                                                                                |  |



### Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          |  |                                                                                                                                             |  |                                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>MARTHA JANE EVANS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 2. Date of Death<br>Month Day Year<br><b>July 13 2000</b>                                                                                                                                                |  | 3. Time of Death<br><b>10:00 A.M.</b>                                                                                                       |  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b>                                                                                                                                               |  | 4c. County of Death<br><b>ANNE ARUNDEL</b>                                                                                                  |  |                                                                                                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>403-38-1623</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.                                                                                                                                                  |  | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 25, 1918</b>                                                                                                                                              |  | 9. Birthplace (State or Foreign Country)<br><b>KENTUCKY</b>                                                                                 |  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent<br>10a. State<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 10b. County<br><b>ANNE ARUNDEL</b>                                                                                                                                                                       |  | 10c. City, Town or Location<br><b>GLEN BURNIE</b>                                                                                           |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                          | 10e. Street and Number<br><b>100 FERNDAL AVENUE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 10f. Zip Code<br><b>21061</b>                                                                                                                                                                            |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                              |  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                  |  |                                                                                                                                             |  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>HOMEMAKER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>OWN HOME</b>                                                                      |  | 16b. Kind of Business/Industry<br><b>OWN HOME</b>                                                                                                                                                        |  |                                                                                                                                             |  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                              | 17. Father's Name (First, Middle, Last)<br><b>ROBERT McGUIRE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ZORA BURNETT</b>                                                                                                                                 |  |                                                                                                                                             |  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                              | 19a. Informant's Name/Relationship (Type, Print) ( <b>DAUGHTER</b> )<br><b>MRS. RUBY JEAN CRACE-HART</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>100 FERNDAL AVENUE, GLEN BURNIE, MD. 21061</b>                                                       |  |                                                                                                                                             |  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                              | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>STONE CHURCH CEMETERY</b>                                                |  | Date<br><b>JULY 17, 2000</b>                                                                                                                                                                      |  | 20c. Location - City or Town, State<br><b>ENOLA, PENNSYLVANIA</b>                                                                                                                                        |  |                                                                                                                                             |  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>                                                                                   |  |                                                                                                                                             |  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                              | 23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br>b. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br>c. <b>CHRONIC RENAL FAILURE</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          |  |                                                                                                                                             |  | Approximate Interval Between Onset and Death                                                       |  |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                            | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |                                                                                                                                             |  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |                                                                                                    |  |
| Division of Vital Records, P.O. Box 68760,                                                                                                                                                                                                                                                                                                   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                       |  | Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                    |  | 26. Place of Death (Check only one)                                                                                                                                                                      |  |                                                                                                                                             |  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                              | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                     |  | 28a. Date of Injury (Month, Day Year)                                                                                                                 |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |  | 28d. Describe how injury occurred                                                                                                           |  |                                                                                                    |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                              |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  | 29b. Signature and title of certifier<br>                                                                                                                                                                |  | 29c. License number<br><b>D43977</b>                                                                                                        |  | 29d. Date signed (Month, Day, Year)<br><b>July 13 2000</b>                                         |  |
|                                                                                                                                                                                                                                                                                                                                              | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>ANDREW BREZINSKI, 301 Hospital Drive, Glen Burnie, MD. 21061</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          |  |                                                                                                                                             |  |                                                                                                    |  |
| State Registrar                                                                                                                                                                                                                                                                                                                              | 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 32. Registrar's Signature<br>                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                                                                                                                                          |  |                                                                                                                                             |  |                                                                                                    |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22354

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                    |                                                                                                                                                                                                   |                                                       |                                                                                      |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1. Decedent's Name (First, Middle, Last)<br>Eugene Victor Edwards                             |                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                    | 2. Date of Death<br>Month Day Year<br>JULY 02, 2000                                                                                                                                               |                                                       | 3. Time of Death<br>8:40 P.M.                                                        |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4a. Facility Name (If not institution, give street and number)<br>ANNE ARUNDEL MEDICAL CENTER |                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                    | 4b. City, Town, or Location of Death<br>ANNAPOLIS                                                                                                                                                 |                                                       | 4c. County of Death<br>ANNE ARUNDEL                                                  |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 5. Social Security Number<br>217-74-1566                                                      |                    | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                          |                                                                                                                    | 7. Age (In yrs. last birthday)<br>32 Yrs.                                                                                                                                                         |                                                       | 8. Date of Birth (Month, Day, Year)<br>Aug. 11, 1967                                 |                                                                                                  | 9. Birthplace (State or Foreign Country)<br>Maryland |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Usual Residence of Decedent                                                                   |                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                    |                                                                                                                                                                                                   |                                                       |                                                                                      |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               | 10b. County<br>N/A |                                                                                                                                                                                                                                                                                                         | 10c. City, Town or Location<br>Baltimore                                                                           |                                                                                                                                                                                                   |                                                       |                                                                                      | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                      |                                                                                                                                                                                                          |  |
| 10e. Street and Number<br>2017 W. Baltimore St.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                    |                                                                                                                                                                                                                                                                                                         | 10f. Zip Code<br>21223                                                                                             |                                                                                                                                                                                                   | 10g. Citizen of What Country?<br>USA                  |                                                                                      |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                    | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                                                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                       |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                 |                                                      |                                                                                                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                    |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)<br>Mover |                                                                                                                                                                                                   |                                                       | 16b. Kind of Business/Industry<br>Furniture Co.                                      |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>Eugene V. Edwards                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               |                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                    | 18. Mother's Name (First, Middle, Maiden Surname)<br>Constance Wilson                                                                                                                             |                                                       |                                                                                      |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print) (uncle)<br>Mr. Alan Wilson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                               |                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3031 Brighton St. Balto, Md. 21216                                                               |                                                       |                                                                                      |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Zion                                                                                                                                                                                                                      |                                                                                                                    |                                                                                                                                                                                                   | 20c. Location - City or Town, State<br>Lansdowne, Md. |                                                                                      |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
| 21. Signature of Funeral Service Licensee<br>Joseph L. Russ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                               |                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                    | 22. Name and Address of Facility<br>Joseph L. Russ Funeral Home<br>2222 W. North Ave. Balto, Md. 21216                                                                                            |                                                       |                                                                                      |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>NARCOTIC INTOXICATION<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |                                                                                               |                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                    |                                                                                                                                                                                                   |                                                       |                                                                                      |                                                                                                  |                                                      | Approximate Interval Between Onset and Death                                                                                                                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                               |                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                    |                                                                                                                                                                                                   |                                                       |                                                                                      |                                                                                                  |                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                    |                                                                                                                                                                                                   |                                                       |                                                                                      |                                                                                                  |                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                    | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                                                                                                    |                                                                                                                                                                                                   |                                                       |                                                                                      |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                       |                                                                                               |                    | 28a. Date of Injury (Month, Day, Year)<br>Found: 7-2-00                                                                                                                                                                                                                                                 |                                                                                                                    | 28b. Time of Injury<br>Found: M                                                                                                                                                                   |                                                       | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                  | 28d. Describe how injury occurred<br>UNKNOWN         |                                                                                                                                                                                                          |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>FOUND: AT WORK                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               |                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>103 CRANES COOK LANE<br>ANNE ARUNDEL COUNTY, MD                                                                                                                                                                         |                                                                                                                    |                                                                                                                                                                                                   |                                                       |                                                                                      |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                   |                                                                                               |                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                    |                                                                                                                                                                                                   |                                                       |                                                                                      |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
| 29b. Signature and title of certifier<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               |                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                    | 29c. License number<br>O.C.M.E.                                                                                                                                                                   |                                                       | 29d. Date signed (Month, Day, Year)<br>JULY 03, 2000                                 |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MARY G. RIPLEY, M.D. 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                               |                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                    |                                                                                                                                                                                                   |                                                       |                                                                                      |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                               |                    | 32. Registrar's Signature<br>[Signature]                                                                                                                                                                                                                                                                |                                                                                                                    |                                                                                                                                                                                                   |                                                       |                                                                                      |                                                                                                  |                                                      |                                                                                                                                                                                                          |  |

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22355

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                    |                                        |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|----------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><i>Lucky Freeman</i>                                                   |                                        |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month: <i>July</i> Day: <i>11</i> Year: <i>2000</i>                                                                                                                       |                                                                                             | 3. Time of Death<br><i>0313</i>                                                                |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><i>THE Johns Hopkins Hospital Baltimore City</i> |                                        |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death                                                                                                                                                          |                                                                                             | 4c. County of Death                                                                            |                                                                                                                                                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><i>256-54-6818</i>                                                                    |                                        | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><i>59</i> Yrs.                                                                                                                                              |                                                                                             | 8. Date of Birth (Month, Day, Year)<br><i>3-24-1941</i>                                        |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><i>Md</i>                                                                                            |                                        | 10b. County<br><i>N/A</i>                                                                                                                         |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><i>Baltimore</i>                                                                                                                                               |                                                                                             | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                  |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                    |                                        |                                                                                                                                                   | 10e. Street and Number<br><i>1804 Rutland Avenue</i>                                                                                                                                                                                                                                        |                                                                                                                                                                                               | 10f. Zip Code<br><i>21213</i>                                                               |                                                                                                | 10g. Citizen of What Country?<br><i>U S A</i>                                                                                                                                                    |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                    |                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                             |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): <i>11th grade</i><br>College (1-4 or 5+): <i>N/A</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                    |                                        |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Crane Operator</i>                                                                                                                                                          |                                                                                                                                                                                               |                                                                                             | 16b. Kind of Business/Industry<br><i>Unk</i>                                                   |                                                                                                                                                                                                  |  |
| 17. Father's Name (First, Middle, Last)<br><i>William Freeman</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                    |                                        |                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Alene Jones</i>                                                                                                                                                                                                                     |                                                                                                                                                                                               |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Lucky Freeman, Jr- Son</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                    |                                        |                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>401 N. Airport Drive Highland Springs, Va 23075</i>                                                                                                                                     |                                                                                                                                                                                               |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                    |                                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>King Memorial Park</i>                                               |                                                                                                                                                                                                                                                                                             | Date<br><i>7-15-00</i>                                                                                                                                                                        |                                                                                             | 20c. Location - City or Town, State<br><i>Randallstown, Md</i>                                 |                                                                                                                                                                                                  |  |
| 21. Signature of Funeral Service Licensee<br><i>Wheeler Edmond</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                    |                                        |                                                                                                                                                   | 22. Name and Address of Facility<br><i>March F/H West<br/>4300 Wabash Avenue Baltimore, Md 21215</i>                                                                                                                                                                                        |                                                                                                                                                                                               |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Sepsis</i><br>Due to (or as a consequence of):<br>b. <i>osteomyelitis</i><br>Due to (or as a consequence of):<br>c. <i>Diabetes</i><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                    |                                        |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                             |                                                                                                | Approximate Interval Between Onset and Death<br><i>4 days</i><br><i>2 weeks</i><br><i>15 years</i>                                                                                               |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Peripheral vascular disease</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                    |                                        |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                             |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                    |                                        |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                             |                                                                                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                    |                                        |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                             |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                    |                                        |                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                               |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                    | 28a. Date of Injury (Month, Day, Year) |                                                                                                                                                   | 28b. Time of Injury<br><i>M</i>                                                                                                                                                                                                                                                             |                                                                                                                                                                                               | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred                                                                                                                                                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                    |                                        |                                                                                                                                                   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                                                                                                                                                               |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                 |                                                                                                                    |                                        |                                                                                                                                                   | 29b. Signature and title of certifier<br><i>C. Smith MD</i>                                                                                                                                                                                                                                 |                                                                                                                                                                                               | 29c. License number<br><i>PES-000</i>                                                       |                                                                                                | 29d. Date signed (Month, Day, Year)<br><i>July, 11 2000</i>                                                                                                                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Craig Smith MD 601 North Caroline Street Baltimore, Maryland 21287</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                    |                                        |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><i>JUL 14 2000</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                    |                                        |                                                                                                                                                   | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                             |                                                                                                |                                                                                                                                                                                                  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22356

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                |                                                            |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>LEONARD FORMAN</b>                       |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2. Date of Death<br>Month <b>JULY</b> Day <b>11</b> Year <b>2000</b> |                                                                                                                                                                                                                                                                                                                                                                                                                | 3. Time of Death<br><b>5:14AM</b>                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                | 4c. County of Death<br><b>N/A</b>                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>220-01-5749</b>                                         |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.                     |                                                                                                                                                                                                                                                                                                                                                                                                                | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 13 1921</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                             |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>MD</b>                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 10b. County<br><b>N/A</b>                                            |                                                                                                                                                                                                                                                                                                                                                                                                                | 10c. City, Town or Location<br><b>BALTIMORE</b>            |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                         | 10e. Street and Number<br><b>7121 PARK HEIGHTS AVE. #903</b>                                                                                                                                                                                                                                |                                                                            | 10f. Zip Code<br><b>21215</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                      | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                            |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                      |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                                                                                                                                                                                                        |                                                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)                                                                                                                                                                                                                                                                                                                               |                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>OWNER</b>                                                                                                                                                                   |                                                                            | 16b. Kind of Business/Industry<br><b>PAPER PRODUCTS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                |                                                            |  |
| 17. Father's Name (First, Middle, Last)<br><b>MORRIS FORMAN</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                                         | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SARAH KATZEN</b>                                                                                                                                                                                                                    |                                                                            | 19a. Informant's Name/Relationship (Type, Print)<br><b>EVELYN FORMAN/ WIFE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7121 PARK HEIGHTS AVE. #903 BALTIMORE, MD. 21215</b>                                                                                                                                                                                                                                                       |                                                            |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>OHEB SHALOM MEMORIAL PARK</b>                                                                                                                                                                                  |                                                                            | 20c. Location - City or Town, State<br><b>7/13/00 REISTERSTOWN, MD.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                |                                                            |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                |                                                                                         | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS. INC.<br/>8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208</b>                                                                                                                                                                   |                                                                            | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Ventricular fibrillation</b><br>Due to (or as a consequence of):<br><b>b. Coronary artery disease</b><br>Due to (or as a consequence of):<br><b>c. Atherosclerosis</b><br>Due to (or as a consequence of):<br><b>d.</b> |                                                                      | Approximate Interval Between Onset and Death<br><b>30'</b><br><b>&gt; 25 yrs</b><br><b>&gt; 25 yrs</b>                                                                                                                                                                                                                                                                                                         |                                                            |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                             |                                                                                         | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                       |                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                |                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                |                                                            |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                         | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                     |                                                                      | 28a. Date of Injury (Month, Day, Year)<br><b>28b. Time of Injury</b><br><b>28c. Injury at Work?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>28d. Describe how injury occurred</b><br><b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b><br><b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b> |                                                            |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                         | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                   |                                                                            | 29c. License number<br><b>DJ 7259</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                      | 29d. Date signed (Month, Day, Year)<br><b>7/14/00</b>                                                                                                                                                                                                                                                                                                                                                          |                                                            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. JOHN MANN MD. 10755 FALLS RD. SUITE 200 LUTHERVILLE, MD. 21093</b>                                                                                                                                                                                                                                                            |                                                                                         | 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                     |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                |                                                            |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 22357

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 410-588-0058.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                               |                                                                                                                                                                                                   |                                                                                                                                                                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br>Mary E. Gauss                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | 2. Date of Death<br>Month Day Year<br>July 12, 2000                                                                                                                                                                                                                                                     |                                                                                                                                               | 3. Time of Death<br>7:25 pm                                                                                                                                                                       |                                                                                                                                                                                                          |
| 4a. Facility Name (If not institution, give street and number)<br>Future Care Canton Harbor Nursing Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>Baltimore City                                                                                        |                                                                                                                                                                                                   | 4c. County of Death<br>N/A                                                                                                                                                                               |
| 5. Social Security Number<br>218-03-2008                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>95 Yrs.                                                                                                                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br>March 2, 1906                                                                                          | 9. Birthplace (State or Foreign Country)<br>MD                                                                                                                                                    |                                                                                                                                                                                                          |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                               |                                                                                                                                                                                                   |                                                                                                                                                                                                          |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 10b. County<br>N/A                                                             | 10c. City, Town or Location<br>Baltimore City                                                                                                                                                                                                                                                           |                                                                                                                                               | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                           |                                                                                                                                                                                                          |
| 10e. Street and Number<br>1300 South Ellwood Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | 10f. Zip Code<br>21230                                                                                                                                                                                                                                                                                  |                                                                                                                                               | 10g. Citizen of What Country?<br>United States                                                                                                                                                    |                                                                                                                                                                                                          |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                                                                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                          |
| 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4or 5+) 0                                                                                                                                                                                   |                                                                                                                                               |                                                                                                                                                                                                   |                                                                                                                                                                                                          |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | 16b. Kind of Business/Industry<br>Own Home                                                                                                                                                                                                                                                              |                                                                                                                                               |                                                                                                                                                                                                   |                                                                                                                                                                                                          |
| 17. Father's Name (First, Middle, Last)<br>(Unknown First Name ) Frederick                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |                                                                                                                                                                                                                                                                                                         | 18. Mother's Name (First, Middle, Maiden Surname)<br>(Unknown First Name ) Williams                                                           |                                                                                                                                                                                                   |                                                                                                                                                                                                          |
| 19a. Informant's Name/Relationship (Type, Print)<br>Clifton F. Gauss, Jr. / Son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                                                                                                                         | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1354 Towson Street, Baltimore Maryland 21230 |                                                                                                                                                                                                   |                                                                                                                                                                                                          |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Loudon Park Cemetery                                                                                                                                                                                                          |                                                                                                                                               | 20c. Location - City or Town, State<br>July 15, 2000 Baltimore MD                                                                                                                                 |                                                                                                                                                                                                          |
| 21. Signature of Funeral Service Licensee<br>Victor P. Doda, Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | 22. Name and Address of Facility<br>Charles L. Stevens Funeral Home, Inc.<br>1501 East Fort Avenue, Baltimore Maryland 21230                                                                                                                                                                            |                                                                                                                                               |                                                                                                                                                                                                   |                                                                                                                                                                                                          |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. INTRA-ABDOMINAL BLEEDING<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                               |                                                                                                                                                                                                   | Approximate Interval Between Onset and Death<br>48 hrs.                                                                                                                                                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DEMENTIA<br>DM                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                               |                                                                                                                                                                                                   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |                                                                                                                                               |                                                                                                                                                                                                   |                                                                                                                                                                                                          |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                               |                                                                                                                                                                                                   |                                                                                                                                                                                                          |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                                                                                                               | 28b. Time of Injury<br>M                                                                                                                                                                          |                                                                                                                                                                                                          |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                       |                                                                                                                                               | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                      |                                                                                                                                                                                                          |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                               |                                                                                                                                                                                                   |                                                                                                                                                                                                          |
| 29b. Signature and title of certifier<br>C. Vergara-Sorres                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                | 29c. License number<br>D16619                                                                                                                                                                                                                                                                           |                                                                                                                                               | 29d. Date signed (Month, Day, Year)<br>July 13, 2000                                                                                                                                              |                                                                                                                                                                                                          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>C. VERGARA-SORRES 1300 S. ELLWOOD BALTIMORE, MD - 21234                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                               |                                                                                                                                                                                                   |                                                                                                                                                                                                          |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                | 32. Registrar's Signature<br>Sparks                                                                                                                                                                                                                                                                     |                                                                                                                                               |                                                                                                                                                                                                   |                                                                                                                                                                                                          |

State Registrar



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State of Maryland / Department of Health and Mental Hygiene

00 22358

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Thomas J. Gavin

2. Date of Death

Month Day Year  
July 13, 2000

3. Time of Death

3:40 pm

4a. Facility Name (If not institution, give street and number)

Manor Care Nursing Home

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

233-01-7229

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

81

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 6, 1919

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

15101 Peachstone Drive

10f. Zip Code

20905

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates:

Unk.

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
216a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cust. Service Engineer

16b. Kind of Business/Industry

Television &amp; Radio

17. Father's Name (First, Middle, Last)

John J. Gavin

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Long

19a. Informant's Name/Relationship (Type, Print)

Christina Jordan / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15101 Peachstone Drive, Silver Spring Maryland 20905

20a. Method of Disposition

☐ Burial ☐ Cremation ☒ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mount Calvary Cemetery

Date

July 18, 2000

20c. Location - City or Town, State

Wheeling, WV

21. Signature of Funeral Service Licensee Victor P. Doda, Jr.

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.  
1501 East Fort Avenue, Baltimore Maryland 2123023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Metastatic Colon Cancer  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. \_\_\_\_\_  
Due to (or as a consequence of):c. \_\_\_\_\_  
Due to (or as a consequence of):

d. \_\_\_\_\_

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Jenny Y. Moy MD

29c. License number

D43260

29d. Date signed (Month, Day, Year)

July 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jenny Y. Moy, M.D. 13952 Baltimore Avenue, Laurel Maryland 20707

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

Benjamin B. Sparks

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene 00 22359

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                  |                                                                                                                                                        |                                                                         |                                                                                                                                                                                                  |                                                             |                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1. Decedent's Name (First, Middle, Last)<br><b>Thelma E. Griffin</b>                     |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                  |                                                                                                                                                        | 2. Date of Death<br>Month <b>July</b> Day <b>11</b> Year <b>2000</b>    |                                                                                                                                                                                                  | 3. Time of Death<br><b>0117 AM</b>                          |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4a. Facility Name (If not institution, give street and number)<br><b>407 Edmunds Way</b> |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                  |                                                                                                                                                        | 4b. City, Town, or Location of Death<br><b>Essex</b>                    |                                                                                                                                                                                                  | 4c. County of Death<br><b>Baltimore</b>                     |                                                               |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 5. Social Security Number<br><b>245-12-4794</b>                                          |                                                                                                                                                                                                                                                                                                        | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs. |                                                                                                                                                        | 8. Date of Birth (Month, Day, Year)<br><b>June 26, 1920</b>             |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Usual Residence of Decedent                                                              |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                  |                                                                                                                                                        |                                                                         |                                                                                                                                                                                                  |                                                             |                                                               |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                          | 10b. County<br><b>Baltimore</b>                                                                                                                                                                                                                                                                        |                                                                            | 10c. City, Town or Location<br><b>Essex</b>                                                                                                                                                   |                                                  |                                                                                                                                                        |                                                                         | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |                                                             |                                                               |  |
| 10e. Street and Number<br><b>407 Edmunds Way</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            | 10f. Zip Code<br><b>21221</b>                                                                                                                                                                 |                                                  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                         |                                                                         |                                                                                                                                                                                                  |                                                             |                                                               |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                      |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                  |                                                                                                                                                        | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                                                                                                                  |                                                             |                                                               |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>                                                                 |                                                  |                                                                                                                                                        | 16b. Kind of Business/Industry<br><b>Own Home</b>                       |                                                                                                                                                                                                  |                                                             |                                                               |  |
| 17. Father's Name (First, Middle, Last)<br><b>UNK.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary E. Garner</b>                                                                             |                                                                         |                                                                                                                                                                                                  |                                                             |                                                               |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Donald Griffin (son)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3222 Magnolia Ridge Road, Annapolis, Md. 21403</b> |                                                                         |                                                                                                                                                                                                  |                                                             |                                                               |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Gardens</b>                                                                                  |                                                  | 20c. Date<br><b>7/14/2000</b>                                                                                                                          |                                                                         | 20d. Location - City or Town, State<br><b>Baltimore, Md.</b>                                                                                                                                     |                                                             |                                                               |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            | 22. Name and Address of Facility<br><b>Brudzinski Funeral Home, P.A.<br/>1407 Old Eastern Avenue, Essex, Maryland 21221</b>                                                                   |                                                  |                                                                                                                                                        |                                                                         |                                                                                                                                                                                                  |                                                             |                                                               |  |
| 23a. Part I. Enter disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                  |                                                                                                                                                        |                                                                         |                                                                                                                                                                                                  |                                                             | Approximate Interval Between Onset and Death<br><b>45 yrs</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                  |                                                                                                                                                        |                                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                             |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                  |                                                                                                                                                        |                                                                         | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                             |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                  |                                                                                                                                                        |                                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                             |                                                               |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                          | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                               |                                                  |                                                                                                                                                        |                                                                         |                                                                                                                                                                                                  |                                                             |                                                               |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                          | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                 |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |                                                  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                       |                                                                         | 28d. Describe how injury occurred                                                                                                                                                                |                                                             |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                                                               |                                                  |                                                                                                                                                        |                                                                         | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                             |                                                               |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                      |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                  |                                                                                                                                                        |                                                                         |                                                                                                                                                                                                  |                                                             |                                                               |  |
| 29b. Signature and Title of certifier<br><br><b>Deputy</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                  | 29c. License number<br><b>D18667</b>                                                                                                                   |                                                                         | 29d. Date signed (Month, Day, Year)<br><b>July 12, 2000</b>                                                                                                                                      |                                                             |                                                               |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PHILIP MILETELLO MD 225. Greene St. Baltimore, Md 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                  |                                                                                                                                                        |                                                                         |                                                                                                                                                                                                  |                                                             |                                                               |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          |                                                                                                                                                                                                                                                                                                        |                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                 |                                                  |                                                                                                                                                        |                                                                         |                                                                                                                                                                                                  |                                                             |                                                               |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 22360

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                                  |                                                            |                                                                                                 |                                                            |                                                                                                                                                                                                          |                                                             |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br><b>Elizabeth Ann George</b>                     |                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                                  | 2. Date of Death<br>Month Day Year<br><b>JULY 09, 2000</b> |                                                                                                 |                                                            |                                                                                                                                                                                                          | 3. Time of Death<br><b>01:20 A.M.</b>                       |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not institution, give street and number)<br><b>7701 Woodyard Road</b> |                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br><b>Clinton</b>     |                                                                                                 |                                                            |                                                                                                                                                                                                          | 4c. County of Death<br><b>Prince George's</b>               |                                              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 5. Social Security Number<br><b>227-45-4892</b>                                             |                                                                                                                                                                                                                                                                                                                      | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>17</b> Yrs.           |                                                                                                 | 8. Date of Birth (Month, Day, Year)<br><b>Dec 26, 1982</b> |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b> |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Usual Residence of Decedent                                                                 |                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                                  |                                                            |                                                                                                 |                                                            |                                                                                                                                                                                                          |                                                             |                                              |  |
| 10a. State<br><b>VA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             | 10b. County<br><b>Stafford</b>                                                                                                                                                                                                                                                                                       |                                                                                | 10c. City, Town or Location<br><b>Fredericksburg</b>                                                                                                                                             |                                                            |                                                                                                 |                                                            | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |                                                             |                                              |  |
| 10e. Street and Number<br><b>540 Galveston Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             |                                                                                                                                                                                                                                                                                                                      |                                                                                | 10f. Zip Code<br><b>22405</b>                                                                                                                                                                    |                                                            |                                                                                                 |                                                            | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                           |                                                             |                                              |  |
| 11. Marital Status<br><b>X</b> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                            |                                                                                                 |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                  |                                                             |                                              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>Student</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                                                                                                                                                                                                                                                                                                                      |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>                                                                      |                                                            |                                                                                                 |                                                            | 16b. Kind of Business/Industry<br><b>High School</b>                                                                                                                                                     |                                                             |                                              |  |
| 17. Father's Name (First, Middle, Last)<br><b>Edward George</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                                                                                                                                                                                                                                                                                      |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Karen Denise Haney</b>                                                                                                                   |                                                            |                                                                                                 |                                                            |                                                                                                                                                                                                          |                                                             |                                              |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Edward George - Father</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             |                                                                                                                                                                                                                                                                                                                      |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>540 Galveston Road, Fredericksburg, VA 22405</b>                                             |                                                            |                                                                                                 |                                                            |                                                                                                                                                                                                          |                                                             |                                              |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Falmouth Cemetery</b>                                                                                                                                                                                                                   |                                                                                | 20c. Date<br><b>7/13/00</b>                                                                                                                                                                      |                                                            | 20d. Location - City or Town, State<br><b>Fredericksburg, VA</b>                                |                                                            |                                                                                                                                                                                                          |                                                             |                                              |  |
| 21. Signature of Funeral Service Licensee<br><b>Joseph M. [Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                                                                                                                                                                                                                                                                                                                      |                                                                                | 22. Name and Address of Facility Found & Sons Funeral Home<br><b>10719 Courthouse Road Fredericksburg Virginia 22407</b>                                                                         |                                                            |                                                                                                 |                                                            |                                                                                                                                                                                                          |                                                             |                                              |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Multiple Injuries</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>f. Due to (or as a consequence of):</b><br><b>g. Due to (or as a consequence of):</b><br><b>h. Due to (or as a consequence of):</b> |                                                                                             |                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                                  |                                                            |                                                                                                 |                                                            |                                                                                                                                                                                                          |                                                             | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             |                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                                  |                                                            |                                                                                                 |                                                            | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                             |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                                  |                                                            |                                                                                                 |                                                            | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                |                                                             |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                                  |                                                            |                                                                                                 |                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                   |                                                             |                                              |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |                                                                                |                                                                                                                                                                                                  |                                                            |                                                                                                 |                                                            |                                                                                                                                                                                                          |                                                             |                                              |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             | 28a. Date of Injury (Month, Day, Year)<br><b>7-9-00</b>                                                                                                                                                                                                                                                              |                                                                                | 28b. Time of Injury<br><b>0039AM</b>                                                                                                                                                             |                                                            | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                            | 28d. Describe how injury occurred<br><b>PASSENGER IN CAR, IMPACT WITH TREE</b>                                                                                                                           |                                                             |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>ROADWAY</b>                                                                                                                                                                                                             |                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>7701 WOODYARD RD CLINTON MD</b>                                                                               |                                                            |                                                                                                 |                                                            |                                                                                                                                                                                                          |                                                             |                                              |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                        |                                                                                             | 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                                          |                                                                                |                                                                                                                                                                                                  |                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                          |                                                            | 29d. Date signed (Month, Day, Year)<br><b>JULY 09, 2000</b>                                                                                                                                              |                                                             |                                              |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Maryland P. KOSOWSKI 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             |                                                                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                                  |                                                            |                                                                                                 |                                                            |                                                                                                                                                                                                          |                                                             |                                              |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                                      |                                                                                |                                                                                                                                                                                                  |                                                            |                                                                                                 |                                                            |                                                                                                                                                                                                          |                                                             |                                              |  |



## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                           |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     |                                                                                                                                                                                               |                                                    |                                                                                  |                                                                                                |                                                      |                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1. Decedent's Name (First, Middle, Last)<br>John Joseph Geraghty                          |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     |                                                                                                                                                                                               | 2. Date of Death<br>Month Day Year<br>JULY 7, 2000 |                                                                                  |                                                                                                | 3. Time of Death<br>4:00 PM                          |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4a. Facility Name (If not institution, give street and number)<br>18611 WARM SPRING COURT |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     |                                                                                                                                                                                               | 4b. City, Town, or Location of Death<br>HAGERSTOWN |                                                                                  |                                                                                                | 4c. County of Death<br>WASHINGTON                    |                                              |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 5. Social Security Number<br>131-22-6683                                                  |                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                           |                                                                                                                                     | 7. Age (In yrs. last birthday)<br>69 Yrs.                                                                                                                                                     |                                                    | 8. Date of Birth (Month, Day, Year)<br>7/13/1930                                 |                                                                                                | 9. Birthplace (State or Foreign Country)<br>New York |                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Usual Residence of Decedent                                                               |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     |                                                                                                                                                                                               |                                                    |                                                                                  |                                                                                                |                                                      |                                              |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           | 10b. County<br>Washington |                                                                                                                                                                                                                                                                                                      | 10c. City, Town or Location<br>Hagerstown                                                                                           |                                                                                                                                                                                               |                                                    |                                                                                  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                      |                                              |
| 10e. Street and Number<br>18611 Warm Springs Ct.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                           |                           |                                                                                                                                                                                                                                                                                                      | 10f. Zip Code<br>21740                                                                                                              |                                                                                                                                                                                               | 10g. Citizen of What Country?<br>USA               |                                                                                  |                                                                                                |                                                      |                                              |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                           |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Korea                                                                                                                                              |                                                                                                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                    |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |                                                      |                                              |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) NA<br>College (1-4 or 5+) 2 years                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                           |                           |                                                                                                                                                                                                                                                                                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Cleaning Service Owner |                                                                                                                                                                                               |                                                    | 16b. Kind of Business/Industry<br>Cleaning                                       |                                                                                                |                                                      |                                              |
| 17. Father's Name (First, Middle, Last)<br>John J. Geraghty                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                           |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     | 18. Mother's Name (First, Middle, Maiden Surname)<br>Linda Golden                                                                                                                             |                                                    |                                                                                  |                                                                                                |                                                      |                                              |
| 19a. Informant's Name/Relationship (Type, Print)<br>Christopher Geraghty (Son)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                           |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>227 Glenridge Drive Winchester, VA 22602                                                     |                                                    |                                                                                  |                                                                                                |                                                      |                                              |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                           |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Shenandoah Memorial Park                                                                                                                                                                                                   |                                                                                                                                     | 20c. Date<br>7/11/00                                                                                                                                                                          |                                                    | 20d. Location - City or Town, State<br>Frederick Co, Virginia                    |                                                                                                |                                                      |                                              |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                           |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave. Dundalk, Maryland 21222                                                                         |                                                    |                                                                                  |                                                                                                |                                                      |                                              |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>ATHROMSCLEROTIC CARDIOVASCULAR DISEASE</u><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                           |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     |                                                                                                                                                                                               |                                                    |                                                                                  |                                                                                                |                                                      | Approximate Interval Between Onset and Death |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     |                                                                                                                                                                                               |                                                    |                                                                                  |                                                                                                |                                                      |                                              |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                           |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     |                                                                                                                                                                                               |                                                    |                                                                                  |                                                                                                |                                                      |                                              |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                           |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                            |                                                    |                                                                                  |                                                                                                |                                                      |                                              |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                           |                           | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE |                                                                                                                                     |                                                                                                                                                                                               |                                                    |                                                                                  |                                                                                                |                                                      |                                              |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                           |                           | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                               |                                                                                                                                     | 28b. Time of Injury<br>M                                                                                                                                                                      |                                                    | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred                    |                                              |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                           |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                  |                                                    |                                                                                  |                                                                                                |                                                      |                                              |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                   |                                                                                           |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     |                                                                                                                                                                                               |                                                    |                                                                                  |                                                                                                |                                                      |                                              |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                           |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     | 29c. License number<br>O.C.M.E                                                                                                                                                                |                                                    |                                                                                  | 29d. Date signed (Month, Day, Year)<br>JULY 8, 2000                                            |                                                      |                                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>YASARAITO A-KOROU 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                           |                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                     |                                                                                                                                                                                               |                                                    |                                                                                  |                                                                                                |                                                      |                                              |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                           |                           | 32. Registrar's Signature<br>                                                                                                                                                                                    |                                                                                                                                     |                                                                                                                                                                                               |                                                    |                                                                                  |                                                                                                |                                                      |                                              |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22362

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                     |                                                                                                                                                                                                                                                                                                                                             |                                                             |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br><b>Gladys Gardner</b>                              |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                           | 2. Date of Death<br>Month <b>July</b> Day <b>9</b> Year <b>2000</b> |                                                                                                                                                                                                                                                                                                                                             | 3. Time of Death<br><b>10:30 AM</b>                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4a. Facility Name (If not institution, give street and number)<br><b>Catonsville Eldercare</b> |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                           | 4b. City, Town, or Location of Death<br><b>Catonsville</b>          |                                                                                                                                                                                                                                                                                                                                             | 4c. County of Death<br><b>N/A</b>                           |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br><b>220-07-8247</b>                                                |                                                                                                                                                   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                           | 7. Age (In yrs. last birthday)<br><b>94</b> Yrs.                    |                                                                                                                                                                                                                                                                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>June 24, 1906</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |                                                                                                                                                   | 10a. State<br><b>Maryland</b>                                              |                                                                                                                                                                                                                                                                                                                                                                                                                           | 10b. County<br><b>N/A</b>                                           |                                                                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>Baltimore</b>             |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                | 10e. Street and Number<br><b>2201 Walbrook Ave. APT. 305</b>                                                                                      |                                                                            | 10f. Zip Code<br><b>21216</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                     | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                                                                                 |                                                             |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                              |                                                                     | 14. Race - American Indian, Black, White, etc.<br><b>African American</b>                                                                                                                                                                                                                                                                   |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary <input type="checkbox"/> Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic</b>                      |                                                                            | 16b. Kind of Business/Industry<br><b>Private Family</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                     | 17. Father's Name (First, Middle, Last)<br><b>Robert Manns</b>                                                                                                                                                                                                                                                                              |                                                             |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Manns</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                | 19a. Informant's Name/Relationship (Type, Print) (daughter)<br><b>Mrs. Fern G. Greene</b>                                                         |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2012 N. Bentalou St. Balto, Md. 21216</b>                                                                                                                                                                                                                                                                             |                                                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                       |                                                             |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                | 20c. Location - City or Town, State<br><b>Balto, Md.</b>                                                                                          |                                                                            | 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                     | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto, Md. 21216</b>                                                                                                                                                                                                                              |                                                             |  |
| 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic Cardiovascular disease</b><br>Due to (or as a consequence of):<br><b>b. Coronary artery disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Due to (or as a consequence of): |                                                                                                | Approximate Interval Between Onset and Death<br><b>years</b><br><b>years</b>                                                                      |                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                          |                                                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                       |                                                             |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                 |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |                                                                     | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                  |                                                             |  |
| 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                | 28b. Time of Injury<br><b>M</b>                                                                                                                   |                                                                            | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                     | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                           |                                                             |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |                                                                            | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                     | 29b. Signature and title of certifier<br><b>Amatum H. Maem MD.</b>                                                                                                                                                                                                                                                                          |                                                             |  |
| 29c. License number<br><b>D15503</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                | 29d. Date signed (Month, Day, Year)<br><b>July 10, 2000</b>                                                                                       |                                                                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>AMATUM H MAEM, 501 Dolphin St Baltimore, MD 21217</b>                                                                                                                                                                                                                                                                          |                                                                     | 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                     |                                                             |  |
| 32. Registrar's Signature<br><b>Benjamin B. Sparks</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                | 33. State Registrar<br><b>MD</b>                                                                                                                  |                                                                            | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020                                                                                                                                                                                                                                                                                                                                             |                                                                     | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form. |                                                             |  |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

00 22363

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                               |                                                                  |                                                                                                                                                                                                  |                                   |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Thelma Gilliam</b>                                |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                               | 2. Date of Death<br>Month <b>7</b> Day <b>10</b> Year <b>'00</b> |                                                                                                                                                                                                  | 3. Time of Death<br><b>5:00 P</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br><b>MARC-Liberty Millennium</b> |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                               | 4b. City, Town, or Location of Death<br><b>Balto, Md 21207</b>   |                                                                                                                                                                                                  | 4c. County of Death<br><b>N/A</b> |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br><b>216-28-0867</b>                                                  |                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                                                                                                                                                                                                                                            | If Under 1 Year<br>Months                                                                                                                                                                     | If Under 24 Hrs.<br>Hours                                                                                                                     | 8. Date of Birth (Month, Day, Year)<br><b>2-21-21</b>            | 9. Birthplace (State or Foreign Country)<br><b>South Carolina</b>                                                                                                                                |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Usual Residence of Decedent                                                                      |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                               |                                                                  |                                                                                                                                                                                                  |                                   |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  | 10b. County<br><b>N/A</b> |                                                                                                                                                   | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                               |                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |                                   |  |
| 10e. Street and Number<br><b>4017 Liberty Heights</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |                           |                                                                                                                                                   | 10f. Zip Code<br><b>21207</b>                                                                                                                                                                                                                                                               |                                                                                                                                                                                               | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                   |                                                                  |                                                                                                                                                                                                  |                                   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                               |                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                                                                                                                       |                                   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                           |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse</b>                                                                                                                                                                   |                                                                                                                                                                                               |                                                                                                                                               | 16b. Kind of Business/Industry<br><b>Nursing Home</b>            |                                                                                                                                                                                                  |                                   |  |
| 17. Father's Name (First, Middle, Last)<br><b>George Watkins</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lila Owens</b>                                                                        |                                                                  |                                                                                                                                                                                                  |                                   |  |
| 19a. Informant's Name/Relationship (Type, Print) (Sister)<br><b>Mrs. Mamie Johnson</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>368 Comet Drive Winnsboro, S.C. 29180</b> |                                                                  |                                                                                                                                                                                                  |                                   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |                           |                                                                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion</b>                                                                                                                                                                                                   |                                                                                                                                                                                               | Date<br><b>7/14/2000</b>                                                                                                                      |                                                                  | 20c. Location - City or Town, State<br><b>Lansdowne, Md.</b>                                                                                                                                     |                                   |  |
| 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto, Md. 21216</b>                                |                                                                  |                                                                                                                                                                                                  |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>End Stage Dementia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Diabetes mellitus</b><br><b>Hypertension</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |                                                                                                  |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                               |                                                                  |                                                                                                                                                                                                  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus</b><br><b>Hypertension</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                  |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                               |                                                                  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |                           |                                                                                                                                                   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                                                                                                                                                               |                                                                                                                                               |                                                                  |                                                                                                                                                                                                  |                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                  |                           |                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                               |                                                                                                                                               |                                                                  |                                                                                                                                                                                                  |                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                           |                                                                                                                                                   | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                                                               | 28b. Time of Injury<br><b>M</b>                                                                                                               |                                                                  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |                                   |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                  |                           |                                                                                                                                                   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                                                                                                                                                               |                                                                                                                                               |                                                                  |                                                                                                                                                                                                  |                                   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                       |                                                                                                  |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                               |                                                                  |                                                                                                                                                                                                  |                                   |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                  |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               | 29c. License number<br><b>D43725</b>                                                                                                          |                                                                  | 29d. Date signed (Month, Day, Year)<br><b>7/13/00</b>                                                                                                                                            |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>TARIQ MATMOOD 201-109 Back River Neck Road Baltimore MD 21221</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                               |                                                                  |                                                                                                                                                                                                  |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                           |                                                                                                                                                   | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                                                                                                                               |                                                                  |                                                                                                                                                                                                  |                                   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

12-10-25

12-10-25

12-10-25

12-10-25

12-10-25

12-10-25

12-10-25

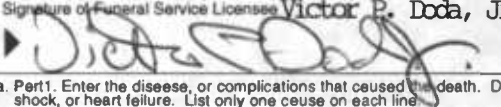
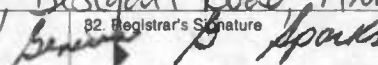
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22364

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   |                                                                                                                                                                                              |                                                                        |                                                                                                |                                                           |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br><b>Helen Helbig</b>                                      |                                                                                                                                                                                                                                                                                             |                                                   |                                                                                                                                                                                              | 2. Date of Death<br>Month <b>July</b> Day <b>11</b> , Year <b>2000</b> |                                                                                                | 3. Time of Death<br><b>07:30</b>                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b> |                                                                                                                                                                                                                                                                                             |                                                   |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Annapolis</b>               |                                                                                                | 4c. County of Death<br><b>Anne Arundel</b>                |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br><b>065-09-8603</b>                                                      | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>104</b> Yrs. | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                                         | 8. Date of Birth (Month, Day, Year)<br><b>April 13, 1896</b>                                   | 9. Birthplace (State or Foreign Country)<br><b>Turkey</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Usual Residence of Decedent                                                                          |                                                                                                                                                                                                                                                                                             |                                                   |                                                                                                                                                                                              |                                                                        |                                                                                                |                                                           |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      | 10b. County<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                          |                                                   | 10c. City, Town or Location<br><b>Annapolis</b>                                                                                                                                              |                                                                        | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                           |  |
| 10e. Street and Number<br><b>2700 S. Haven Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   | 10f. Zip Code<br><b>21401</b>                                                                                                                                                                |                                                                        | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                           |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                        | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                           |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                                                |                                                                        | 16b. Kind of Business/Industry<br><b>Own Home</b>                                              |                                                           |  |
| 17. Father's Name (First, Middle, Last)<br><b>Ernest Makraki</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marta Grecorasco</b>                                                                                                                 |                                                                        |                                                                                                |                                                           |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Mongelli / Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>100 Spencer Road, Woodstock NY NY 12498</b>                                              |                                                                        |                                                                                                |                                                           |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodstock Cemetery</b>                                                                                                                                                                                         |                                                   | Date<br><b>7-15-00</b>                                                                                                                                                                       |                                                                        | 20c. Location - City or Town, State<br><b>Woodstock, NY</b>                                    |                                                           |  |
| 21. Signature of Funeral Service Licensee <b>Victor P. Doda, Jr.</b><br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   | 22. Name and Address of Facility<br><b>Charles L. Stevens Funeral Home, Inc.<br/>1501 East Fort Avenue, Baltimore Maryland 21230</b>                                                         |                                                                        |                                                                                                |                                                           |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>b. Chronic Obstructive pulmonary disease 30 years</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   |                                                                                                                                                                                              |                                                                        |                                                                                                |                                                           |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   |                                                                                                                                                                                              |                                                                        |                                                                                                |                                                           |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   |                                                                                                                                                                                              |                                                                        |                                                                                                |                                                           |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   |                                                                                                                                                                                              |                                                                        |                                                                                                |                                                           |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial fibrillation.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   |                                                                                                                                                                                              |                                                                        |                                                                                                |                                                           |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                      | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                   |                                                                                                                                                                                              |                                                                        |                                                                                                |                                                           |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                   | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                                        | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |                                                           |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   | 28d. Describe how injury occurred                                                                                                                                                            |                                                                        |                                                                                                |                                                           |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   |                                                                                                                                                                                              |                                                                        |                                                                                                |                                                           |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                          |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   |                                                                                                                                                                                              |                                                                        |                                                                                                |                                                           |  |
| 29b. Signature and title of certifier<br><b>Barbara L. Bean MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   | 29c. License number<br><b>D39497</b>                                                                                                                                                         |                                                                        | 29d. Date signed (Month, Day, Year)<br><b>July 11th 2000</b>                                   |                                                           |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Suite 301, 900, Bestgate Road, Annapolis MD 21401</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   |                                                                                                                                                                                              |                                                                        |                                                                                                |                                                           |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                   | 32. Registrar's Signature<br>                                                                             |                                                                        |                                                                                                |                                                           |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

W

12

Investment

Makind

0

Homes

Own Home

Martha Greenhouse

Mary Mondelli \ Daughter

100 Spencer Road, Woodstock NY 12498

xx

Woodstock Cemetery

Woodstock, NY

Victor P. Doda, Jr.

Charles L. Stevens Funeral Home, Inc.  
1501 East Fort Avenue, Baltimore Maryland 21230

*Handwritten signature*

WIDE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22365

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                    |                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                              |                                                    |                                                                                                                    |                                                      |                                                                                                                                                                                                  |                                                      |                                              |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br>Steven Paul Hocheder                   |                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br>July 09 2000 |                                                                                                                    |                                                      |                                                                                                                                                                                                  | 3. Time of Death<br>8:30 P.M.                        |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4a. Facility Name (If not institution, give street and number)<br>2331 Gillis Road |                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br>Mount Airy |                                                                                                                    |                                                      |                                                                                                                                                                                                  | 4c. County of Death<br>Carroll                       |                                              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br>218-70-0218                                           |                                                                                                                                                                                                                                                                                                      | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br>40 Yrs.          |                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br>Oct. 08, 1959 |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br>Maryland |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Usual Residence of Decedent                                                        |                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                              |                                                    |                                                                                                                    |                                                      |                                                                                                                                                                                                  |                                                      |                                              |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                    | 10b. County<br>Carroll                                                                                                                                                                                                                                                                               |                                                                            | 10c. City, Town or Location<br>Westminster                                                                                                                                                   |                                                    |                                                                                                                    |                                                      | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |                                                      |                                              |  |
| 10e. Street and Number<br>1730 Peppermint Lane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                    |                                                                                                                                                                                                                                                                                                      |                                                                            | 10f. Zip Code<br>21157                                                                                                                                                                       |                                                    | 10g. Citizen of What Country?<br>USA                                                                               |                                                      |                                                                                                                                                                                                  |                                                      |                                              |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                    | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                    |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                    |                                                                                                                    |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                 |                                                      |                                              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                    |                                                                                                                                                                                                                                                                                                      |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Claims Adjuster                                                                 |                                                    |                                                                                                                    |                                                      | 16b. Kind of Business/Industry<br>Insurance                                                                                                                                                      |                                                      |                                              |  |
| 17. Father's Name (First, Middle, Last)<br>Paul W. Hocheder                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                    |                                                                                                                                                                                                                                                                                                      |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br>Maxine E. Doman                                                                                                                         |                                                    |                                                                                                                    |                                                      |                                                                                                                                                                                                  |                                                      |                                              |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Amy M. Hocheder                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                    |                                                                                                                                                                                                                                                                                                      |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1730 Peppermint Lane, Westminster, Maryland 21157                                           |                                                    |                                                                                                                    |                                                      |                                                                                                                                                                                                  |                                                      |                                              |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>All County Cremation Services, Inc.                                                                                                                                                                                        |                                                                            | Date<br>7/12/00                                                                                                                                                                              |                                                    | 20c. Location - City or Town, State<br>Sykesville, Maryland                                                        |                                                      |                                                                                                                                                                                                  |                                                      |                                              |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> MOOS 35                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                    |                                                                                                                                                                                                                                                                                                      |                                                                            | 22. Name and Address of Facility<br>Slack Funeral Home, P.A.<br>3871 Old Columbia Pike, Ellicott City, Maryland 21043                                                                        |                                                    |                                                                                                                    |                                                      |                                                                                                                                                                                                  |                                                      |                                              |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Hanging<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                    |                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                              |                                                    |                                                                                                                    |                                                      |                                                                                                                                                                                                  |                                                      | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                    |                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                              |                                                    |                                                                                                                    |                                                      | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                      |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                    |                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                              |                                                    |                                                                                                                    |                                                      | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                            |                                                      |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                    |                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                              |                                                    |                                                                                                                    |                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                               |                                                      |                                              |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                    | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) at scene |                                                                            |                                                                                                                                                                                              |                                                    |                                                                                                                    |                                                      |                                                                                                                                                                                                  |                                                      |                                              |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                            |                                                                                    | 28a. Date of Injury (Month, Day, Year)<br>07-09-2000                                                                                                                                                                                                                                                 |                                                                            | 28b. Time of Injury<br>8:00 PM                                                                                                                                                               |                                                    | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                        |                                                      | 28d. Describe how injury occurred<br>Subject hanged self.                                                                                                                                        |                                                      |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                    | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Residence                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                              |                                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2331 Gillis Road Mount Airy, Maryland |                                                      |                                                                                                                                                                                                  |                                                      |                                              |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                        |                                                                                    |                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                              |                                                    |                                                                                                                    |                                                      |                                                                                                                                                                                                  |                                                      |                                              |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                    |                                                                                                                                                                                                                                                                                                      |                                                                            | 29c. License number<br>O.C.M.E.                                                                                                                                                              |                                                    |                                                                                                                    |                                                      | 29d. Date signed (Month, Day, Year)<br>July 10, 2000                                                                                                                                             |                                                      |                                              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Mary G. Ripple, M.D. 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                    |                                                                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                              |                                                    |                                                                                                                    |                                                      |                                                                                                                                                                                                  |                                                      |                                              |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                    | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                              |                                                    |                                                                                                                    |                                                      |                                                                                                                                                                                                  |                                                      |                                              |  |





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State of Maryland / Department of Health and Mental Hygiene

00 22366

AMENDED ITEMS 23a, 27, 28a-f PER ME G785 7/18/00 AH

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                  |                                                           |                                                                                                                                                    |                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1. Decedent's Name (First, Middle, Last)<br><b>Craig Louis Hauf</b>                               |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                  | 2. Date of Death<br>Month Day Year<br><b>JULY 11 2000</b> |                                                                                                                                                    | 3. Time of Death<br><b>18:11 PM</b>                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4a. Facility Name (If not institution, give street and number)<br><b>FRANKLIN SQUARE HOSPITAL</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br><b>ESSEX</b>      |                                                                                                                                                    | 4c. County of Death<br><b>BALTIMORE</b>                     |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 5. Social Security Number<br><b>220-72-1144</b>                                                   |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>42</b> Yrs.          |                                                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 26, 1958</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                       |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>Maryland</b>                                              |                                                                                                                                                                                                  | 10b. County<br><b>Baltimore</b>                           |                                                                                                                                                    | 10c. City, Town or Location<br><b>Essex</b>                 |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                   | 10e. Street and Number<br><b>431 S. Taylor Avenue</b>                                                                                                                                                                                                                                       |                                                                            | 10f. Zip Code<br><b>21221</b>                                                                                                                                                                    |                                                           | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                     |                                                             |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                            |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Steel Worker</b>                                                                                                                                                            |                                                                            | 16b. Kind of Business/Industry<br><b>Steel Mill</b>                                                                                                                                              |                                                           |                                                                                                                                                    |                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>Martin Hauf</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Freda Haines</b>                                                                                                                         |                                                           |                                                                                                                                                    |                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Martin Hauf (father)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>431 S. Taylor Ave. Balto., Maryland 21221</b>                                                |                                                           |                                                                                                                                                    |                                                             |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cemetery</b>                                                                                                                                                                                  |                                                                            | 20c. Location - City or Town, State<br><b>7/14/00 Baltimore, Maryland</b>                                                                                                                        |                                                           |                                                                                                                                                    |                                                             |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                   | 22. Name and Address of Facility<br><b>Bruzdzinski Funeral Home</b><br><b>1407 Old Eastern Ave. Essex, Md. 21221</b>                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                  |                                                           |                                                                                                                                                    |                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. NARCOTIC INTOXICATION</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                                                                                                   | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                  |                                                           |                                                                                                                                                    |                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                           |                                                                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                            | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                            |                                                           | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                             |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                                  |                                                           |                                                                                                                                                    |                                                             |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                   | 28a. Date of Injury (Month, Day, Year)<br><b>FOUND: 7/11/00</b>                                                                                                                                                                                                                             |                                                                            | 28b. Time of Injury<br><b>FOUND: 5:33 PM</b>                                                                                                                                                     |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                        |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>FOUND IN HOUSE</b>                                                                                                                                                                             |                                                                            | 28d. Describe how injury occurred<br><b>SUBJECT INGESTED DRUGS</b>                                                                                                                               |                                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>205 RIVERSIDE DRIVE, BALTO., MD</b>                             |                                                             |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                           |                                                                                                   | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                   |                                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                           |                                                           | 29d. Date signed (Month, Day, Year)<br><b>JULY 12, 2000</b>                                                                                        |                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JACK M. TAMS, M.D.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   | <b>111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                  |                                                           |                                                                                                                                                    |                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                   | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                  |                                                           |                                                                                                                                                    |                                                             |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

00 22367

## Certificate of Death

Reg. No.

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        |                                                                                                                                                                                                  |  |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                         | 1. Decedent's Name (First, Middle, Last)<br><b>EDNA HOLLAND</b>                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month Day Year<br><b>JULY 11th 2000</b>                                                                                                                                   |  |                                                                                  |                                                                        | 3. Time of Death<br><b>03:20</b>                                                                                                                                                                 |  |
|                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>Levindale Nursing Home</b>                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                                                                      |  |                                                                                  |                                                                        | 4c. County of Death<br><b>N/A</b>                                                                                                                                                                |  |
| Funeral<br>Director                                                       | 5. Social Security Number<br><b>216-28-1975</b>                                                                                                                                                                                                                                                                                                                                                                                                  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.                                                                                                                                              |  | 8. Date of Birth (Month, Day, Year)<br><b>May 17, 1917</b>                       |                                                                        | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>                                                                                                                                 |  |
|                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        |                                                                                                                                                                                                  |  |
| To Be Completed by Funeral Director                                       | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10b. County<br><b>N/A</b>                                                                                                                                                                                                                                                                   |  | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                               |  |                                                                                  |                                                                        | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |  |
|                                                                           | 10e. Street and Number<br><b>4910 Chalgrove Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  | 10f. Zip Code<br><b>21215</b>                                                                                                                                                                 |  | 10g. Citizen of What Country?<br><b>USA</b>                                      |                                                                        |                                                                                                                                                                                                  |  |
|                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |                                                                                  | 14. Race - American Indian, Black, White, etc.<br><b>Asio-American</b> |                                                                                                                                                                                                  |  |
|                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>                                                                                                                                                                                                                                                                                                            |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cafeteria Worker Balto. School System</b>                                                                                                                                   |  |                                                                                                                                                                                               |  | 16b. Kind of Business/Industry                                                   |                                                                        |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner                             | 17. Father's Name (First, Middle, Last)<br><b>James Brunswick</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Clinton</b>                                                                                                                 |  |                                                                                  |                                                                        |                                                                                                                                                                                                  |  |
|                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ms. Madeline Armstrong (daughter)</b>                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4910 Chalgrove Ave. Balto. Md. 21215</b>                                                  |  |                                                                                  |                                                                        |                                                                                                                                                                                                  |  |
|                                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                               |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus Mem. Park</b>                                                                                                                                                                                          |  | 20c. Date<br><b>7/17/2000</b>                                                                                                                                                                 |  | 20d. Location - City or Town, State<br><b>Balto. Md.</b>                         |                                                                        |                                                                                                                                                                                                  |  |
|                                                                           | 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto. Md. 21216</b>                                                                                |  |                                                                                  |                                                                        |                                                                                                                                                                                                  |  |
| Physician<br>/Medical<br>Examiner                                         | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        | Approximate Interval Between Onset and Death                                                                                                                                                     |  |
|                                                                           | a. <b>SEPSIS</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        | 4 days                                                                                                                                                                                           |  |
|                                                                           | b. <b>CVA</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        | 2 YEARS                                                                                                                                                                                          |  |
|                                                                           | c. <b>DEMENTIA</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        | 2 YEARS                                                                                                                                                                                          |  |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |  |
|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |  |
|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        |                                                                                                                                                                                                  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner      | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        |                                                                                                                                                                                                  |  |
|                                                                           | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                       |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. Time of Injury<br>M                                                                                                                                                                      |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                        | 28d. Describe how injury occurred                                                                                                                                                                |  |
|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  |                                                                                                                                                                                               |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |                                                                        |                                                                                                                                                                                                  |  |
|                                                                           | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                        |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        |                                                                                                                                                                                                  |  |
| State Registrar                                                           | 29b. Signature and title of certifier<br><b>Donna M. Evenley M.D.</b>                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 29c. License number<br><b>D0054739</b>                                                                                                                                                        |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 11th 2000</b>                     |                                                                        |                                                                                                                                                                                                  |  |
|                                                                           | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DONNA M. EVENLEY, M.D. LEVINDALE NURSING HOME</b>                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        |                                                                                                                                                                                                  |  |
| AH                                                                        | 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                          |  | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        |                                                                                                                                                                                                  |  |
|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                               |  |                                                                                  |                                                                        |                                                                                                                                                                                                  |  |

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State of Maryland / Department of Health and Mental Hygiene

00 22368

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                               |                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                            |                                                                                                                                         |                                |                                                                                                                              |                                                 |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Velma Elizabeth Jennings</b>                   |                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 2. Date of Death<br>Month Day Year<br><b>JULY 12, 2000</b> |                                                                                                                                         |                                |                                                                                                                              | 3. Time of Death<br><b>19:17 PM</b>             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>3926 ECHODALE AVENUE</b> |                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                                                                                                                         |                                |                                                                                                                              | 4c. County of Death<br><b>N/A</b>               |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>207-09-1394</b>                                               |                                                                                                                                                                                                                                                                                                          | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.           |                                                                                                                                         | If Under 1 Year<br>Months Days |                                                                                                                              | If Under 24 Hrs.<br>Hours Min.                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><b>04-19-1915</b>                                      |                                                                                                                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><b>Md.</b>                                   |                                                                                                                                         | 10b. County<br><b>N/A</b>      |                                                                                                                              | 10c. City, Town or Location<br><b>Baltimore</b> |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                               | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                           |                                                                            | 10a. Street and Number<br><b>3926 Echodale Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                            | 10f. Zip Code<br><b>21206</b>                                                                                                           |                                | 10g. Citizen of What Country?<br><b>USA</b>                                                                                  |                                                 |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                        |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                             |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                 |                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) |                                                 |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>                                                                                                                                                                                                                                                                                            |                                                                                               | 16b. Kind of Business/Industry<br><b>Spice Company</b>                                                                                                                                                                                                                                                   |                                                                            | 17. Father's Name (First, Middle, Last)<br><b>John Fahl</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Uaeffley</b>                                                          |                                | 19a. Informant's Name/Relationship (Type, Print)<br><b>John Annello-Friend</b>                                               |                                                 |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4009 Glenarm Ave. Baltimore, Md. 21206</b>                                                                                                                                                                                                                                                                            |                                                                                               | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                    |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                                                            | 20c. Date<br><b>7/14/2000</b>                                                                                                           |                                | 20d. Location - City or Town, State<br><b>Towson, Md</b>                                                                     |                                                 |  |
| 21. Signature of Funeral Service Licensee<br><b>Gary R. DiGiovanni</b>                                                                                                                                                                                                                                                                                                                                                    |                                                                                               | 22. Name and Address of Facility<br><b>Leonard J. Ruck Funeral Home<br/>5305 Harford Rd. Baltimore, Md 21214</b>                                                                                                                                                                                         |                                                                            | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Atherosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |                                                            | Approximate Interval Between Onset and Death                                                                                            |                                |                                                                                                                              |                                                 |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                                               | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                         |                                                                            | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                     |                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                |                                                                                                                              |                                                 |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                               | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |                                                                            | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                |                                                            | 28a. Date of Injury (Month, Day Year)                                                                                                   |                                | 28b. Time of Injury<br><b>M</b>                                                                                              |                                                 |  |
| 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                               | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                        |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                            |                                |                                                                                                                              |                                                 |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                               | 29b. Signature and title of certifier<br><b>Dennis J. Chuteau</b>                                                                                                                                                                                                                                        |                                                                            | 29c. License number<br><b>OCME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                            | 29d. Date signed (Month, Day, Year)<br><b>JULY 13, 2000</b>                                                                             |                                |                                                                                                                              |                                                 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis Chuteau</b>                                                                                                                                                                                                                                                                                                             |                                                                                               | 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                  |                                                                            | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                            | 33. State Registrar<br><b>JUL 14 2000</b>                                                                                               |                                |                                                                                                                              |                                                 |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22369

amend item 18 per fh G785 7/13/00 yg

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET SAGE HILDRETH JOHNSTON

2. Date of Death

Month Day Year  
July 11, 2000

3. Time of Death

9:45 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HOSPICE OF BALTIMORE: GILCHRIST CENTER

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore County

5. Social Security Number

230-20-0203

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar 8, 1911

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore County

10c. City, Town or Location

Towson

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

615 Chestnut Avenue

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)  
5+16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Psychologist

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

William Hampton Sage, III

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Bradbury Rich  
~~Margaret Elizabeth Rich~~

19a. Informant's Name/Relationship (Type, Print)

Dr. Arthur M. Hildreth (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

912 Rolandvue Road, Towson, Maryland 21204

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory 7/12/2000 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Martin D. Lawson

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.  
6500 York Road, Baltimore, Maryland 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. thoracic Aortic Aneurysm

Approximate Interval Between Onset and Death

1 week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify) Hospice

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anthony Riley, MD

29c. License number

D25205

29d. Date signed (Month, Day, Year)

July 11, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Riley GABC 6701 N. Charles St. Balto. md 21204

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

James P. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at 202-696-2020.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00 22370

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edward W. Kemske

2. Date of Death

JULY 11

Day

2000

Year

3. Time of Death

11:30 pm

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

212-32-3687

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Jun 10, 1905

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baldwin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4806 Carroll Manor Rd.

10f. Zip Code

21013

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Self employed

16b. Kind of Business/Industry

Farmer

17. Father's Name (First, Middle, Last)

Charles Kemske

18. Mother's Name (First, Middle, Maiden Surname)

Frieda Jungfer

19a. Informant's Name/Relationship (Type, Print)

Mildred C. Kemske

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4806 Carroll Manor Rd., Baldwin, MD 21013

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. John's Lutheran

Date

Jul 15

2000

20c. Location - City or Town, State

Parkville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Chapel  
8800 Harford Rd. Parkville, MD23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Acute Myocardial Infarction

Due to (or as a consequence of):

b.

Atherosclerotic Heart Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D19166

29d. Date signed (Month, Day, Year)

7/12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. Charles St. Towson, Maryland 21286

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22371

amend 29c per dvr G785 7/14/00 yg

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                          |                                                                                                                                         |                                                              |                                                                        |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>TINA M KELLY</b>                              |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 2. Date of Death<br>Month Day Year<br><b>JULY 6 2000</b> |                                                                                                                                         | 3. Time of Death<br><b>8:15am</b>                            |                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>1805 Sunnyside Lane</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4b. City, Town, or Location of Death<br><b>Essex</b>     |                                                                                                                                         | 4c. County of Death<br><b>Baltimore</b>                      |                                                                        |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>214-56-9954</b>                                              |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 7. Age (In yrs. last birthday)<br><b>41</b> Yrs.         |                                                                                                                                         | 8. Date of Birth (Month, Day, Year)<br><b>August 4, 1958</b> |                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>                             |                                                                                                                                                                                                                                                                                             | 10a. State<br><b>MD</b>                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 10b. County<br><b>Baltimore</b>                          |                                                                                                                                         | 10c. City, Town or Location<br><b>Essex</b>                  |                                                                        |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                              |                                                                            | 10e. Street and Number<br><b>1805 Sunnyside Lane</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                          | 10f. Zip Code<br><b>21221</b>                                                                                                           |                                                              | 10g. Citizen of What Country?<br><b>USA</b>                            |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                      |                                                          | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                 |                                                              |                                                                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b><br>College (1-4 or 5+) <b>Collega</b>                                                                                                                                                                                                                                                                          |                                                                                              | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bank Teller</b>                                                                                                                                                             |                                                                            | 16b. Kind of Business/Industry<br><b>Bank Of America</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                          | 17. Father's Name (First, Middle, Last)<br><b>Glen Cain</b>                                                                             |                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Joan Prior</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Thomas B. Kelly / husband</b>                                                                                                                                                                                                                                                                                                                                      |                                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1805 Sunnyside Lane Baltimore Md. 21221</b>                                                                                                                                             |                                                                            | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                             |                                                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory Inc. 7/8/2000</b>                          |                                                              | 20c. Location - City or Town, State<br><b>Baltimore Md.</b>            |  |
| 21. Signature of Funeral Service Licensee<br><b>R. Terry Connelly</b>                                                                                                                                                                                                                                                                                                                                                     |                                                                                              | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Essex<br/>300 Mace Ave. Baltimore Md. 21221</b>                                                                                                                                                                             |                                                                            | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Acute myelocytic leukemia</b><br>Due to (or as a consequence of):<br><b>b. Chemotherapy induced neutropenia</b><br>Due to (or as a consequence of):<br><b>c. Undifferentiated carcinoma of unknown origin</b><br>Due to (or as a consequence of):<br><b>d.</b> |                                                          | Approximate interval Between Onset and Death                                                                                            |                                                              |                                                                        |  |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                               |                                                                                              | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |                                                                            | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                             |                                                          | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                              |                                                                        |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                              | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                         |                                                          | 28a. Date of Injury (Month, Day Year)                                                                                                   |                                                              | 28b. Time of Injury<br><b>M</b>                                        |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                          |                                                                                              | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                            |                                                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                            |                                                              |                                                                        |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                              | 29b. Signature and title of certifier<br><b>Alfred B. Brooks MD</b>                                                                                                                                                                                                                         |                                                                            | 29c. License number<br><b>24898 VAD001</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                          | 29d. Date signed (Month, Day, Year)<br><b>7/7/2000</b>                                                                                  |                                                              |                                                                        |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Alfred B. Brooks MD 5409 Green Glen Lane Alexandria Virginia 22315</b>                                                                                                                                                                                                                                                         |                                                                                              | 31. Data filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                     |                                                                            | 32. Registrar's Signature<br><b>Benjamin B. Spotts</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                          |                                                                                                                                         |                                                              |                                                                        |  |






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State of Maryland / Department of Health and Mental Hygiene

00 22372

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                        |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                          |                                                                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1. Decedent's Name (First, Middle, Last)<br>Deborah Lynn Kane                          |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br>July 10 2000 |                          |                                                                                                    |                                                                                      | 3. Time of Death<br>4:50PM                           |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4a. Facility Name (If not institution, give street and number)<br>6225 York Rd. #E 113 |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>Baltimore  |                          |                                                                                                    |                                                                                      | 4c. County of Death<br>---                           |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 5. Social Security Number<br>212-70-1410                                               |                                                                                                                                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br>44 Yrs.          |                          | 8. Date of Birth (Month, Day, Year)<br>August 10, 1955                                             |                                                                                      | 9. Birthplace (State or Foreign Country)<br>Maryland |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Usual Residence of Decedent                                                            |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         | 10c. City, Town or Location<br>Baltimore           |                          | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                      |                                                      |                                                                                                                                                                                                          |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        | 10b. County                                                                                                                                           |                                                                                | 10e. Street and Number<br>6225 York Road Apt. E 113                                                                                                                                                                                                                                                     |                                                    |                          |                                                                                                    | 10f. Zip Code<br>21239                                                               |                                                      | 10g. Citizen of What Country?<br>U.S.A.                                                                                                                                                                  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                        |                                                    |                          |                                                                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |                                                      |                                                                                                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 yrs.<br>College (1-4 or 5+) 1 yr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                        |                                                                                                                                                       |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Actress                                                                                                                                                                                    |                                                    |                          |                                                                                                    | 16b. Kind of Business/Industry<br>Acting                                             |                                                      |                                                                                                                                                                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>Clarence J. Kane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                        |                                                                                                                                                       |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Virginia Cobb                                                                                                                                                                                                                                      |                                                    |                          |                                                                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Joseph Mechlinski- Son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                        |                                                                                                                                                       |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>303 E. Hamburg St., Baltimore, MD 21230                                                                                                                                                                |                                                    |                          |                                                                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                        |                                                                                                                                                       |                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Corp.                                                                                                                                                                                                         |                                                    |                          |                                                                                                    | Date<br>7/14/00                                                                      |                                                      | 20c. Location - City or Town, State<br>Towson, MD                                                                                                                                                        |  |
| 21. Signature of Funeral Service Licensee<br> William G. Dau                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                        |                                                                                                                                                       |                                                                                | 22. Name and Address of Facility<br>Leonard J. Ruck Funeral Home, Inc.<br>5305 Harford Rd., Baltimore, MD 21214                                                                                                                                                                                         |                                                    |                          |                                                                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <u>DIABETES</u><br>Due to (or as a consequence of):<br><br>b. <u>KIDNEY TRANSPLANT</u><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                        |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                          |                                                                                                    |                                                                                      |                                                      | Approximate Interval Between Onset and Death                                                                                                                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><u>CHRONIC PAN ON NARCOTICS</u><br><br><u>DECAIDUS ULCER</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                        |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                          |                                                                                                    |                                                                                      |                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                        |                                                                                                                                                       |                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |                                                    |                          |                                                                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                        |                                                                                                                                                       |                                                                                | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                    |                          |                                                                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                        |                                                                                                                                                       |                                                                                | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                    | 28b. Time of Injury<br>M |                                                                                                    | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                      | 28d. Describe how injury occurred                                                                                                                                                                        |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                        |                                                                                                                                                       |                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                    |                          |                                                                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                       |                                                                                        |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                          |                                                                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                        |                                                                                                                                                       |                                                                                | 29c. License number<br>019329                                                                                                                                                                                                                                                                           |                                                    |                          |                                                                                                    | 29d. Date signed (Month, Day, Year)<br>7/11/00                                       |                                                      |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JAMES H MEISNER 6565 N. CHALLES ST SUITE 41, BALTIMORE MD 21204                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                        |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                          |                                                                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                        |                                                                                                                                                       |                                                                                | 32. Registrar's Signature<br>                                                                                                                                                                                        |                                                    |                          |                                                                                                    |                                                                                      |                                                      |                                                                                                                                                                                                          |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

00 22373

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>FANNER</b>                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <b>JULY</b> Day <b>10</b> Year <b>2000</b>                                                                                                                            |                                                                 | 3. Time of Death<br><b>5:54am</b>                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>                                                                                                                         |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                                                                                                                        |                                                                 | 4c. County of Death<br><b>N/A</b>                                                                                                                                                                |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>213-12-3161</b>                                                                                                                                                                                       | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.                                                                                                                                                | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 5, 1911</b>      | 9. Birthplace (State or Foreign Country)<br><b>Canada</b>                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                          | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                         | 10b. County<br><b>Baltimore</b>                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>Dundalk</b>                                                                                                                                                   |                                                                 | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br><b>108 Shipway</b>                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                             | 10f. Zip Code<br><b>21222</b>                                                                                                                                                                   |                                                                 | 10g. Citizen of What Country?<br><b>United States</b>                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6 Years</b> College (1-4 or 5+)                                                                                                     |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Seamstress</b>                                                                  |                                                                 | 16b. Kind of Business/Industry<br><b>Sewing Industry</b>                                                                                                                                         |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                | 17. Father's Name (First, Middle, Last)<br><b>Pasquale Cofelice</b>                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Theresa Salvatori</b>                                                                                                                   |                                                                 |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Jeannette Curry (Daughter)</b>                                                                                                                                            |                                                                                                                                                                                                                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1209 Clover Valley Way Edgewood, MD 21040</b>                                               |                                                                 |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Ht. of Jesus Cem.</b>                                                                                                                                                                                   | Date<br><b>7/12/2000</b>                                                                                                                                                                        | 20c. Location - City or Town, State<br><b>Dundalk, Maryland</b> |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>                                                                   |                                                                 |                                                                                                                                                                                                  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Ischemic STENOSIS</b> |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                 |                                                                 | Approximate Interval Between Onset and Death<br><b>15 YEARS</b>                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Due to (or as a consequence of):                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Due to (or as a consequence of):                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Due to (or as a consequence of):                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CORONARY ARTERY DISEASE<br/>GASTROINTESTINAL BLEED</b>                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                 |                                                                 | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                 |                                                                 | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                 |                                                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                    | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                             | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                     | 28d. Describe how injury occurred                               |                                                                                                                                                                                                  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                  |
| 29b. Signature and title of certifier<br><b>David A. Kapko MD</b>                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                       | 29c. License number<br><b>20313</b>                                                                                                                                                                                                                                                         |                                                                                                                                                                                                 | 29d. Date signed (Month, Day, Year)<br><b>July 12, 2000</b>     |                                                                                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DAVID A. KAPKO, MD 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224</b>                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                       | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                  |



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State of Maryland / Department of Health and Mental Hygiene

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## Certificate of Death

Reg. No.

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><b>DAVID KRIEGER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month <b>JULY</b> Day <b>9</b> Year <b>2000</b>                                                                                      |                                                                              | 3. Time of Death<br><b>11PM</b>                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br><b>LORIEN NURSING &amp; REHABILITATION CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>COLUMBIA</b>                                                                                                  |                                                                              | 4c. County of Death<br><b>HOWARD</b>                                                                                                                                                              |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><b>212-07-8165</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.                                                                                                         | 8. Date of Birth<br>Month <b>JAN</b> Day <b>23</b> Year <b>1908</b>          | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>                                                                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                                                                              |                                                                                                                                                                                                   |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 10b. County<br><b>HOWARD</b>                                                                                                                                                                                                                                                                            | 10c. City, Town or Location<br><b>CLARKSVILLE</b>                                                                                                        |                                                                              | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br><b>5940 GENTLE CALL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         | 10f. Zip Code<br><b>21029</b>                                                                                                                            |                                                                              | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:    |                                                                              | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>PHARMACIST ASSISTANT</b> |                                                                              |                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 16. Kind of Business/Industry<br><b>PHARMACEUTICAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         | 17. Father's Name (First, Middle, Last)<br><b>HERMAN KRIEGER</b>                                                                                         |                                                                              |                                                                                                                                                                                                   |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>YETTA RUBIN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         | 19a. Informant's Name/Relationship (Type, Print)<br><b>SHELDON KRIEGER/SON</b>                                                                           |                                                                              |                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5940 GENTLE CALL CLARKSVILLE, MD 21029</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                                                                              |                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>HAR SINAI CONGREGATION</b>                                                 |                                                                              | 20c. Location - City or Town, State<br><b>7/13/00 BALTIMORE, MD.</b>                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS. INC.<br/>8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208</b>                                 |                                                                              |                                                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Hypertension</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Parkinson's Disease, Anemia, malnutrition</b><br>Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>years</b> |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                                                                              |                                                                                                                                                                                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinson's Disease, Anemia, malnutrition</b>                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                                                                              |                                                                                                                                                                                                   |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                               |                                                                                                                                                          |                                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                            |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                          |                                                                              |                                                                                                                                                                                                   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 28a. Date of Injury (Month, Day, Year)<br><b>July 10, 2000</b>                                                                                                                                                                                                                                          |                                                                                                                                                          | 28b. Time of Injury<br><b>M</b>                                              |                                                                                                                                                                                                   |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                       |                                                                                                                                                          | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                                                                                   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                                                                              |                                                                                                                                                                                                   |
| 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 29c. License number<br><b>D28998</b>                                                                                                                                                                                                                                                                    |                                                                                                                                                          | 29d. Date signed (Month, Day, Year)<br><b>July 10, 2000</b>                  |                                                                                                                                                                                                   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PRITAM S SAINI MD<br/>9101 Cherry Lane Suite 211 Laurel MD 20708</b>                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                          |                                                                              |                                                                                                                                                                                                   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                                         |                                                                                                                                                          |                                                                              |                                                                                                                                                                                                   |

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22375

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                 |                                                        |                                                                  |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br>Janet Catherine Kelbaugh                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                 | 2. Date of Death<br>Month Day Year<br>July 7, 2000     |                                                                  | 3. Time of Death<br>9:15pm                                                                         |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br>902 St. Andrews Way                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                               | 4b. City, Town, or Location of Death<br>Bel Air                                                                                                                                                  |                                                                                                 | 4c. County of Death<br>Harford                         |                                                                  |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br>213-38-8358                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                               | 7. Age (In yrs. last birthday)<br>59 Yrs.                                                                                                                                                        |                                                                                                 | 8. Date of Birth (Month, Day, Year)<br>12/9/1940       |                                                                  | 9. Birthplace (State or Foreign Country)<br>Maryland                                               |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                 |                                                        |                                                                  |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                              | 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         | 10b. County<br>Harford                                                                                                                                |                                                                                                                               | 10c. City, Town or Location<br>Bel Air                                                                                                                                                           |                                                                                                 |                                                        |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10e. Street and Number<br>902 St. Andrews Way                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                               | 10f. Zip Code<br>21015                                                                                                                                                                           |                                                                                                 | 10g. Citizen of What Country?<br>U.S.A.                |                                                                  |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                 |                                                        | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Property Manager |                                                                                                                                                                                                  |                                                                                                 | 16b. Kind of Business/Industry<br>Thornhill Properties |                                                                  |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. Father's Name (First, Middle, Last)<br>George W. Waxter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Gertrude Leffler                                                                                                                            |                                                                                                 |                                                        |                                                                  |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 19a. Informant's Name/Relationship (Type, Print)<br>Donald Kelbaugh/Husband                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>902 St. Andrews Way Bel Air, MD 21015                                                           |                                                                                                 |                                                        |                                                                  |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.                                                       |                                                                                                                               | Data<br>7/8/00                                                                                                                                                                                   |                                                                                                 | 20c. Location - City or Town, State<br>Baltimore, MD   |                                                                  |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                               | 22. Name and Address of Facility<br>E.F. Lassahn Funeral Home, P.A.<br>11750 Belair Road Kingsville, MD 21087                                                                                    |                                                                                                 |                                                        |                                                                  |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Ovarian Carcinoma</u><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                 |                                                        |                                                                  |                                                                                                    |                                                                                                                                             | Approximate Interval Between Onset and Death<br>3 years                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                 |                                                        |                                                                  |                                                                                                    |                                                                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                 |                                                        |                                                                  |                                                                                                    | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                                                                                                                          |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                 |                                                        |                                                                  |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                                       | 28b. Time of Injury<br>M                                                                                                      |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                        | 28d. Describe how injury occurred                                |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                    |                                                        |                                                                  |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                               |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  | 29c. License number<br>D41490                                                                   |                                                        | 29d. Date signed (Month, Day, Year)<br>July 8, 2000              |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Michael McCallum, MD 9105 Franklin Square Dr. Balt. MD 21237                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                 |                                                        |                                                                  |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                                                                                                                       |                                                                                                                               |                                                                                                                                                                                                  |                                                                                                 |                                                        |                                                                  |                                                                                                    |                                                                                                                                             |                                                                                                                                                                                                          |  |

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene 00 22376

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HILDA LINTHICUM

2. Date of Death

Month Day Year  
JULY 13 2000

3. Time of Death

5:00 PM

4a. Facility Name (If not institution, give street and number)

4940 Ten Oaks Rd

4b. City, Town, or Location of Death

Dayton

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

214-01-8061

6. Sex

1 ☐ M 2 ☒ F X

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 31, 1911

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Dayton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No X

10e. Street and Number

4243 Linthicum Rd.

10f. Zip Code

21036

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Realtor

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

Covington B. Zepp

18. Mother's Name (First, Middle, Maiden Surname)

Anna Louise Lehmann

19a. Informant's Name/Relationship (Type, Print)

Ms. Joyce L. Diamond Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4310 Linthicum Rd. Dayton, MD 21036

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Memorial Gardens

Date

07/18/2000

20c. Location - City or Town, State

Marriottsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Slack Funeral Home, P.A.  
3871 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 YEARS

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

ASSISTED LIVING HOME

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

MD

29c. License number

D51860

29d. Date signed (Month, Day, Year)

JULY 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JONATHAN FULT MD 3460 ELLICOTT CTR DR #103 ELLICOTT CITY MD 21043

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-691-2024.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22377

amend item 20c per fh G785 7/14/00 yg

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                                                              |                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>Agnes Cecelia Lewis</b>                  |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <b>July</b> Day <b>11</b> Year <b>2000</b>                                                                        |                                                                                                                                                                                              | 3. Time of Death<br><b>04:00am</b>             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital</b> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                    |                                                                                                                                                                                              | 4c. County of Death                            |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>579-32-7405</b>                                         | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.                                                                                            | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>02 05 13</b>                                  |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>M.D.</b>                                                                                     |                                                                                                                                                                                              |                                                |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                                                              |                                                |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                         | 10b. County<br><b>NA</b>                                                                                                                                                                                                                                                                    |                                                                                                                                             | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                              |                                                |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                                                              |                                                |
| 10e. Street and Number<br><b>3615 Fords Lane Apt #306</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                         |                                                                                                                                                                                                                                                                                             | 10f. Zip Code<br><b>21215</b>                                                                                                               |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>U.S.A.</b> |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                                                              |                                                |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+) <b>na</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Presser</b>                                                                                                                                                                 |                                                                                                                                             | 16b. Kind of Business/Industry<br><b>Maryland Hospital Laundry Inc.</b>                                                                                                                      |                                                |
| 17. Father's Name (First, Middle, Last)<br><b>Augustine Carter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                         |                                                                                                                                                                                                                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Emma Green</b>                                                                      |                                                                                                                                                                                              |                                                |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Wilhelmine Corbitt-Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                         |                                                                                                                                                                                                                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1924 Manitou Lane, Hanover Md 21076</b> |                                                                                                                                                                                              |                                                |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>                                                                                                                                                                                         |                                                                                                                                             | 20c. Location - City or Town, State<br><b>7/14/00 Randallstown, Md</b>                                                                                                                       |                                                |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                         | 22. Name and Address of Facility<br><b>March F/H West</b><br><b>4300 Wabash Ave, Baltimore, Md</b>                                                                                                                                                                                          |                                                                                                                                             |                                                                                                                                                                                              |                                                |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Lactic Acidosis</b><br>Due to (or as a consequence of):<br><b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><b>Aortic Stenosis</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>24 hours</b><br><b>10 years</b><br><b>5 years</b> |                                                                                         | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                |                                                                                                                                             |                                                                                                                                                                                              |                                                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                                                              |                                                |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                                                              |                                                |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                                                              |                                                |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                                                              |                                                |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                         | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                             |                                                                                                                                                                                              |                                                |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                         | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                             | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                         | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                                                                                             | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                |
| 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                 |                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                                                              |                                                |
| 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                         | 29c. License number<br><b>RES-000</b>                                                                                                                                                                                                                                                       |                                                                                                                                             | 29d. Date signed (Month, Day, Year)<br><b>July 11, 2000</b>                                                                                                                                  |                                                |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Myechia Minter Sinai Hospital</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                                                              |                                                |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                         | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                             |                                                                                                                                             |                                                                                                                                                                                              |                                                |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

00 22378

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                           |                                                                                                                                                                                              |                                  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br><b>RICHARD LEWIS</b>                                    |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>JULY 09 2000</b> |                                                                                                                                                                                              | 3. Time of Death<br><b>23:41</b> |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4a. Facility Name (If not institution, give street and number)<br><b>The Johns Hopkins Hospital</b> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |                                                                                                                                                                                              | 4c. County of Death              |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br><b>579-38-9938</b>                                                     | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.          | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.   |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 11, 1931</b>                                        |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>Hawaii</b> |                                                                                                                                                                                              |                                  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                           |                                                                                                                                                                                              |                                  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                     | 10b. County<br><b>Anne Arundel</b>                                                                                                                                                                                                                                                          |                                                           | 10c. City, Town or Location<br><b>Edgewater</b>                                                                                                                                              |                                  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                           |                                                                                                                                                                                              |                                  |
| 10e. Street and Number<br><b>133 River Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                     | 10f. Zip Code<br><b>21037</b>                                                                                                                                                                                                                                                               |                                                           | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                  |                                  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                        |                                                                                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                           |                                                                                                                                                                                              |                                  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>1</b>                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Union Printer</b>                                                                                                                                                           |                                                           | 16b. Kind of Business/Industry<br><b>Printing</b>                                                                                                                                            |                                  |
| 17. Father's Name (First, Middle, Last)<br><b>Richard P. Lewis, Sr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                     | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pauline Dubrow</b>                                                                                                                                                                                                                  |                                                           |                                                                                                                                                                                              |                                  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ida K. Lewis (Wife)</b>                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>133 River Road, Edgewater, MD 21037</b>                                                                                                                                                 |                                                           |                                                                                                                                                                                              |                                  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                 |                                                                                                     | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>                                                                                                                                                                                            |                                                           | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>                                                                                                                                  |                                  |
| 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                     | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A.<br/>12 Ridgely Avenue, Annapolis, MD 21401</b>                                                                                                                                                                           |                                                           |                                                                                                                                                                                              |                                  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ANOXIC BRAIN INJURY</b><br>Due to (or as a consequence of):<br><b>b. CARDIAC ARREST</b><br>Due to (or as a consequence of):<br><b>c. ESOPHAGEAL CANCER</b><br>Due to (or as a consequence of):<br><b>d.</b> |                                                                                                     | Approximate Interval Between Onset and Death<br><b>2 DAYS</b><br><b>2 DAYS</b><br><b>UNKNOWN</b>                                                                                                                                                                                            |                                                           |                                                                                                                                                                                              |                                  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                     | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |                                                           |                                                                                                                                                                                              |                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                     | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                       |                                                           | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                           |                                  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                     | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                           |                                                                                                                                                                                              |                                  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                         |                                                                                                     | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                           | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                     | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                             |                                                                                                     | 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                 |                                                           | 29c. License number<br><b>RES-000</b>                                                                                                                                                        |                                  |
| 29d. Date signed (Month, Day, Year)<br><b>July 09, 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                           |                                                                                                                                                                                              |                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SUNIL SINGHAL, JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE ST., BALTIMORE, MD</b>                                                                                                                                                                                                                                                                                                                              |                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                           |                                                                                                                                                                                              |                                  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                     | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                             |                                                           |                                                                                                                                                                                              |                                  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **00 22379**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mildred Amelia Lautenberger

2. Date of Death

Month Day Year  
July 13, 2000

3. Time of Death

4 A.M.

4a. Facility Name (If not institution, give street and number)

1024 Green Hill Farm Road

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

204-24-2327

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Aug 16, 1932

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1024 Green Hill Farm Road

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Agent

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

Henry F. Koedding

18. Mother's Name (First, Middle, Maiden Surname)

Caroline M. Strobel

19a. Informant's Name/Relationship (Type, Print)

John R. Lautenberger Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1024 Green Hill Farm Road Reisterstown, MD 21136

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation Serv.

Date

7/14/00

20c. Location - City or Town, State

Hampstead, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Eline Funeral Home

11824 Reisterstown Road Reisterstown, MD 21136

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Relapsed lymphoma

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D55139

29d. Date signed (Month, Day, Year)

July 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sally Arai Johns Hopkins Hospital, Baltimore, Maryland

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

State  
Registrar

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22380

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES LONG

2. Date of Death

Month Day Year  
JULY 8, 2000

3. Time of Death

12:40PM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

204-16-9969

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 19, 1926

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15 Vista Mobile Drive

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1945-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Trucking Industry

17. Father's Name (First, Middle, Last)

John Ambrose Long

18. Mother's Name (First, Middle, Maiden Surname)

Mertyl Long

19a. Informant's Name/Relationship (Type, Print) (Friend)

Ms. Elizabeth R. Minnick

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15 Vista Mobile Drive Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holly Hill Mem. Gdns. 7/12/2000

Date

20c. Location - City or Town, State

Middle River, MD

21. Signature of Funeral Service Licensee

Donald R. Watson Jr.

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

three days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

coronary artery disease, dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Elizabeth Pynadath MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

JULY 8, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elizabeth Pynadath, M.D. Johns Hopkins Bayview Medical Ctr. Baltimore, MD 21224

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22381

## Certificate of Death

Reg. No.

|                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                      | 1. Decedent's Name (First, Middle, Last)<br>Joseph Francis Laniewski, Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                   |  | 2. Date of Death<br>Month Day Year<br>July 11, 2000                                                                                                                                                                                                                                                     |  | 3. Time of Death<br>3:00 PM                                                          |  |
|                                                                                                                                                        | 4a. Facility Name (If not institution, give street and number)<br>Genesis Heritage Meridian Eldercare Ctr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br>Dundalk                                                                                                                                                                                                                                                         |  | 4c. County of Death<br>Baltimore                                                     |  |
| Funeral<br>Director                                                                                                                                    | 5. Social Security Number<br>212-34-2355                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br>63 Yrs.                                                                                                                                                                                                                                                               |  | 8. Date of Birth (Month, Day, Year)<br>April 26, 1937                                |  |
|                                                                                                                                                        | 9. Birthplace (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10a. State<br>MD                                                                                                                                  |  | 10b. County<br>N/A                                                                                                                                                                                                                                                                                      |  | 10c. City, Town or Location<br>Baltimore                                             |  |
| To Be Completed by Funeral Director                                                                                                                    | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 10e. Street and Number<br>7200 Dunmanway                                                                                                          |  | 10f. Zip Code<br>21222                                                                                                                                                                                                                                                                                  |  | 10g. Citizen of What Country?<br>U.S.A.                                              |  |
|                                                                                                                                                        | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                            |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|                                                                                                                                                        | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Truck Driver                         |  | 16b. Kind of Business/Industry<br>Freight                                                                                                                                                                                                                                                               |  |                                                                                      |  |
|                                                                                                                                                        | 17. Father's Name (First, Middle, Last)<br>Joseph S. Laniewski, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Helen M. Cyryca                                                                                                                                                                                                                                    |  |                                                                                      |  |
|                                                                                                                                                        | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Patricia Howard-Sister                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>100 North Manheim St. York, PA 17402                                                                                                                                                                   |  |                                                                                      |  |
|                                                                                                                                                        | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Stanislaus Cemetery                                                 |  | 20c. Location - City or Town, State<br>Baltimore, Maryland                                                                                                                                                                                                                                              |  | 20d. Date<br>7/13/00                                                                 |  |
|                                                                                                                                                        | 21. Signature of Funeral Service Licensee<br>Heather Cain                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                   |  | 22. Name and Address of Facility<br>Leonard J. Ruck, Inc.<br>5305 Harford Road Baltimore, Maryland 21214                                                                                                                                                                                                |  |                                                                                      |  |
|                                                                                                                                                        | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. METASTATIC ADENOCARCINOMA<br>Due to (or as a consequence of):<br>b. DIABETES MELLITUS<br>Due to (or as a consequence of):<br>c. HYPERTENSION<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
|                                                                                                                                                        | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
|                                                                                                                                                        | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner                                                                                   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                      |  |
|                                                                                                                                                        | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                     |  | 28a. Date of Injury (Month, Day, Year)                                                                                                            |  | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                                |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                                                                                                                                        | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                            |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |  |                                                                                      |  |
|                                                                                                                                                        | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
|                                                                                                                                                        | 29b. Signature and title of certifier<br>Sarinder K. Tulka M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                   |  | 29c. License number<br>D27188                                                                                                                                                                                                                                                                           |  | 29d. Date signed (Month, Day, Year)<br>7/12/00                                       |  |
| State Registrar                                                                                                                                        | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Sarinder K. Tulka 2 Market Place Baltimore MD 21222                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
|                                                                                                                                                        | 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                   |  | 32. Registrar's Signature<br>Benjamin Sparks                                                                                                                                                                                                                                                            |  |                                                                                      |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22382

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                 |                                                           |                                                                                                                                                       |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                  |                                                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Patricia Ward Leonard                                                                                                                                                                               |                                                           |                                                                                                                                                       |                               | 2. Date of Death<br>Month Day Year<br>July 12 2000                                                                                                                                               |                                                                                      |                                                           |                                                                  | 3. Time of Death<br>12:30 PM                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>685 Budleigh Circle                                                                                                                                                           |                                                           |                                                                                                                                                       |                               | 4b. City, Town, or Location of Death<br>Timonium                                                                                                                                                 |                                                                                      |                                                           |                                                                  | 4c. County of Death<br>Baltimore                                                                   |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>212-50-1609                                                                                                                                                                                                        |                                                           | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                               | 7. Age (In yrs. last birthday)<br>53 Yrs.                                                                                                                                                        |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>September 1 1946   |                                                                  | 9. Birthplace (State or Foreign Country)<br>Maryland                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                     |                                                           |                                                                                                                                                       |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                  |                                                                                                    |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br>Maryland                                                                                                                                                                                                                          |                                                           | 10b. County<br>Baltimore                                                                                                                              |                               | 10c. City, Town or Location<br>Timonium                                                                                                                                                          |                                                                                      |                                                           |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br>685 Budleigh Circle                                                                                                                                                                                                   |                                                           |                                                                                                                                                       |                               | 10f. Zip Code<br>21093                                                                                                                                                                           |                                                                                      | 10g. Citizen of What Country?<br>United States            |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                          |                                                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                      |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                           |                                                           |                                                                                                                                                       |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Florist                                                                             |                                                                                      |                                                           | 16b. Kind of Business/Industry<br>Retail Florist                 |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>William Robert Ward                                                                                                                                                                                  |                                                           |                                                                                                                                                       |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dorothy Mary Chester                                                                                                                        |                                                                                      |                                                           |                                                                  |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                 | 19a. Informant's Name/Relationship (Type, Print)<br>Daniel D. Leonard, Jr. (Son)                                                                                                                                                                |                                                           |                                                                                                                                                       |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5981 Sandy Ridge Court Elkridge, Maryland 21075                                                 |                                                                                      |                                                           |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |                                                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dulaney Valley Memorial Gardens                                             |                               | Date<br>7/15/00                                                                                                                                                                                  |                                                                                      | 20c. Location - City or Town, State<br>Timonium, Maryland |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>Steven T. Bittle                                                                                                                                                                                   |                                                           |                                                                                                                                                       |                               | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Funeral Home, Inc.<br>6500 York Road Baltimore, Maryland 21212                                                                            |                                                                                      |                                                           |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |                                                           |                                                                                                                                                       |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                        |                                                           |                                                                                                                                                       |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                  |                                                                                                    |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                 |                                                           |                                                                                                                                                       |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                  |                                                                                                    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                 |                                                           |                                                                                                                                                       |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                  |                                                                                                    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                 |                                                           |                                                                                                                                                       |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                  |                                                                                                    |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                 |                                                           |                                                                                                                                                       |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                  |                                                                                                    |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                       |                                                                                                                                                                                                                                                 |                                                           |                                                                                                                                                       |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                  |                                                                                                    |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                     |                                                                                                                                                                                                                                                 | 28a. Date of Injury (Month, Day Year)                     |                                                                                                                                                       | 28b. Time of Injury<br>M      |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                           | 28d. Describe how injury occurred                                |                                                                                                    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                 | 29b. Signature and title of certifier<br>Gwen Bolling, MD |                                                                                                                                                       | 29c. License number<br>D25570 |                                                                                                                                                                                                  | 29d. Date signed (Month, Day, Year)<br>July 13, 2000                                 |                                                           |                                                                  |                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Gwen Bolling, M.D. 7801 York Road Suite 101-A Towson, Maryland 21286                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                 |                                                           |                                                                                                                                                       |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                  |                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                 | 32. Registrar's Signature<br>[Signature]                  |                                                                                                                                                       |                               |                                                                                                                                                                                                  |                                                                                      |                                                           |                                                                  |                                                                                                    |  |



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State of Maryland / Department of Health and Mental Hygiene

00 22383

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>John Richard Lansinger                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 2. Date of Death<br>Month Day Year<br>July 12 2000                                                                                                                                                                                                                                                                                                               |  | 3. Time of Death<br>2:00pm                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>St. Agnes Healthcare                                                                                                                                                                                                                                                                                                                                        |  |                                                                                |  | 4b. City, Town, or Location of Death<br>Baltimore                                                                                                                                                                                                                                                                                                                |  | 4c. County of Death<br>N/A                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| Funeral<br>Director                           | 5. Social Security Number<br>216-40-0204                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br>59 Yrs.                                                                                                                                                                                                                                                                                                                        |  | 8. Date of Birth (Month, Day, Year)<br>February 4, 41                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
|                                               | 9. Birthplace (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                                                                                                                                          |  | 10a. State<br>Maryland                                                         |  | 10b. County<br>Anne Arundel                                                                                                                                                                                                                                                                                                                                      |  | 10c. City, Town or Location<br>Glen Burnie                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |  |                                                                                |  | 10e. Street and Number<br>6508 Pampona Drive                                                                                                                                                                                                                                                                                                                     |  | 10f. Zip Code<br>21061                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |
|                                               | 10g. Citizen of What Country?<br>USA                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                           |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                                                                            |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                           |  |                                                                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                                                                                                                                                                                 |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12                                                                                                                                                                                                                                                                                                                                                         |  |
|                                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Line Mechanic                                                                                                                                                                                                                                                                                                    |  |                                                                                |  | 16b. Kind of Business/Industry<br>MEDCO                                                                                                                                                                                                                                                                                                                          |  | 17. Father's Name (First, Middle, Last)<br>John Raymond Lansinger                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ruth C. Hillman                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 19a. Informant's Name/Relationship (Type, Print)<br>Constance Lansinger/Wife                                                                                                                                                                                                                                                                                     |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6508 Pampona Dr. Glen Burnie, Maryland 21061                                                                                                                                                                                                                                                                                                                                    |  |
|                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                               |  |                                                                                |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Meadowridge Memorial                                                                                                                                                                                                                                                                   |  | 20c. Location - City or Town, State<br>7/15/00 Elkridge, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Thomas J. Spaulding Jr.                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                |  | 22. Name and Address of Facility<br>David J. Weber Funeral Homes, P.A.<br>5311 Edmondson Avenue Baltimore, MD 21229                                                                                                                                                                                                                                              |  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Acute Renal Failure<br>Due to (or as a consequence of):<br>b. Metastatic Prostate Cancer<br>Due to (or as a consequence of):<br>c. Leukopenia<br>Due to (or as a consequence of):<br>d. Anemia |  |
|                                               | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                      |  |                                                                                |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                        |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Urinary Tract Infection                                                                                                                                                                                                                                                                             |  |                                                                                |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                            |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                                                                                                                                                                          |  |
|                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |  |                                                                                |  | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                        |  | 28d. Describe how injury occurred<br>28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                                                                |  | 29b. Signature and title of certifier<br>Anne Koran, MD                                                                                                                                                                                                                                                                                                          |  | 29c. License number<br>P-12704                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |
|                                               | 29d. Date signed (Month, Day, Year)<br>JULY 12/2000                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ANNA KORAN<br>STAGNES Healthcare 900 Caton Ave Baltimore MD 21229                                                                                                                                                                                                        |  | 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                |  | 33. Date of Death<br>JUL 12 2000                                                                                                                                                                                                                                                                                                                                 |  | 34. Time of Death<br>2:00pm                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |
|                                               | 35. Name of Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit record.                                                              |  |                                                                                |  | 36. Name of Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit record. |  | 37. Name of Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit record.                                                                                                                 |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22384

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PHYLLIS E. MACMILLAN

2. Date of Death

Month Day Year  
JULY 12, 2000

3. Time of Death

1830

4a. Facility Name (If not institution, give street and number)

ST. JOSEPH MEDICAL CTR - E.P.

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

217-01-4092

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
APRIL 17, 1911

9. Birthplace (State or Foreign Country)

W. VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

LUTHERVILLE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

300 W. SEMINARY AVE

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

+4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

PETER W. TRAYNOR

18. Mother's Name (First, Middle, Maiden Surname)

ELLA STEINER

19a. Informant's Name/Relationship (Type, Print)

CATHERINE KLEIN, NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1402 MAGERS LANDING MONKTON, MD. 2111

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DRUID RIDGE CEMETERY

Date

JULY 14, 2000

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EVANS FUNERAL CHAPEL

2225 YORK RD. TIMONUM, MD. 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Bronchitis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dementia

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D19166

29d. Date signed (Month, Day, Year)

JULY 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH BALDANZA, MD. 10629 YORK RD COCKEYSVILLE, MD. 21030

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No. 00-22385

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Aleen Louise Moran

2. Date of Death

Month  
JulyDay  
06Year  
2000

3. Time of Death

04:25 P.M.

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

220-80-0318

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 25, 1960

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4809 Lauren Court

10f. Zip Code

21043

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

R.N.

16b. Kind of Business/Industry

Health Care

17. Father's Name (First, Middle, Last)

Robert C. Marien

18. Mother's Name (First, Middle, Maiden Surname)

Jan M. Young

19a. Informant's Name/Relationship (Type, Print)

Ms. Katie Moran

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

627 S. Dean Street Baltimore, MD 21224

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

All County Cremation Serv 7/7/00 Sykesville, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility Inc. Slack Funeral Home, PA

3871 Old Columbia Pike, Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ANOXIC ENCEPHALOPATHY COMPLICATING A CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

CORONARY ARTERY DISSECTION AND

b. THROMBOSIS WITH HEALED TRANSMURAL INFARCTION / CONTUSION

Due to (or as a consequence of):

c. REMOTE CHEST TRAUMA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☒ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

10/89

28b. Time of  
Injury

Unknown

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

Street

28d. Describe how injury occurred

Chest trauma  
from motor vehicle accident28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

Long Island, New York

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 7, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jack M. Titus, M.D.

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 21 2000

32. Registrar's Signature

Benita B. Sparks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22386

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |
|-----------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Jimmie R. Maricle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  | 2. Date of Death<br>Month Day Year<br>July 9 2000                                                                                                                                                 |  |                                                                                      |                                                                  | 3. Time of Death<br>7:20 pm                                                                        |  |                                                                                                                                                                                                          |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>1121 Colony Ridge Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 4b. City, Town, or Location of Death<br>Odenton                                                                                                                                                   |  |                                                                                      |                                                                  | 4c. County of Death<br>Anne Arundel                                                                |  |                                                                                                                                                                                                          |  |
| Funeral<br>Director                           | 5. Social Security Number<br>568-66-1173                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                              |  | 7. Age (In yrs. last birthday)<br>54 Yrs.                                                                                                                                                         |  | 8. Date of Birth (Month, Day, Year)<br>Jan. 6, 1946                                  |                                                                  | 9. Birthplace (State or Foreign Country)<br>Texas                                                  |  |                                                                                                                                                                                                          |  |
|                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |
| To Be Completed by Funeral Director           | 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10b. County<br>Anne Arundel                                                                                                                                                                                                                                                                             |  | 10c. City, Town or Location<br>Odenton                                                                                                                                                            |  |                                                                                      |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |                                                                                                                                                                                                          |  |
|                                               | 10e. Street and Number<br>1121 Colony Ridge Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                         |  | 10f. Zip Code<br>21113                                                                                                                                                                            |  | 10g. Citizen of What Country?<br>USA                                                 |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1972-95                                                                                                                                             |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                    |  |                                                                                                                                                                                                          |  |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Master Sergeant                                                                      |  |                                                                                      | 16b. Kind of Business/Industry<br>U.S. Air Force                 |                                                                                                    |  |                                                                                                                                                                                                          |  |
|                                               | 17. Father's Name (First, Middle, Last)<br>James Maricle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Vada Gregory                                                                                                                                 |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Maria Maricle (Wife)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                         |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1121 Colony Ridge Road, Odenton, MD 21113                                                        |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |
|                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Maryland Veterans Cem.                                                                                                                                                                                                        |  | Date<br>07/13 2000                                                                                                                                                                                |  | 20c. Location - City or Town, State<br>Crownsville, MD                               |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |
|                                               | 21. Signature of Funeral Service Licensee<br><i>Batash A. Arnold</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br>Hardesty Funeral Home, P.A.<br>12 Ridgely Avenue, Annapolis, MD 21401                                                                                         |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |
|                                               | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Metastatic colorectal cancer</i><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                  |                                                                                                    |  | Approximate Interval Between Onset and Death<br><i>6 months</i>                                                                                                                                          |  |
|                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                  |                                                                                                    |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                  |                                                                                                    |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |  |
|                                               | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |
|                                               | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                    |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |  | 28b. Time of Injury<br>M                                                                                                                                                                          |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                  |  |                                                                                                                                                                                                          |  |
|                                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |
|                                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                  |                                                                                                    |  | 29b. Signature and title of certifier<br><i>Larry Waterbury, M.D.</i>                                                                                                                                    |  |
| State Registrar                               | 29c. License number<br>20-9559                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | 29d. Date signed (Month, Day, Year)<br>7/11/00                                                                                                                                                                                                                                                          |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>LARRY WATERBURY, MD, 4940 EASTERN AVE., BALT., MD. 21224</i>                                           |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |
|                                               | 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 32. Registrar's Signature<br><i>Batash A. Arnold</i>                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                   |  |                                                                                      |                                                                  |                                                                                                    |  |                                                                                                                                                                                                          |  |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene 00 22387

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br>William Joseph McCracken                  |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br>July 8, 2000 |                                                                                                                                                                                              |                                |                                                                                                | 3. Time of Death<br>6:02 PM                                      |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br>8633 Black Oak Road |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br>Baltimore  |                                                                                                                                                                                              |                                |                                                                                                | 4c. County of Death<br>Baltimore                                 |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br>218-14-4691                                              |                          | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                             |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br>78 Yrs.          |                                                                                                                                                                                              | If Under 1 Year<br>Months Days |                                                                                                | 8. Date of Birth (Month, Day, Year)<br>Sept. 2, 1921             |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br>Maryland |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                           |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       | 10b. County<br>Baltimore |                                                                                                                                                        | 10c. City, Town or Location<br>Baltimore                                                                                                                                                                                                                                                    |                                                    |                                                                                                                                                                                              |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| 10e. Street and Number<br>8633 Black Oak Road                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                          |                                                                                                                                                        | 10f. Zip Code<br>21234                                                                                                                                                                                                                                                                      |                                                    |                                                                                                                                                                                              |                                | 10g. Citizen of What Country?<br>U.S.A.                                                        |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                       |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No WWII<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                             |                                                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (14 or 5+)                                                                                                                                                                                                                                                                                                      |                                                                                       |                          |                                                                                                                                                        | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Engineer                                                                                                                                                                       |                                                    |                                                                                                                                                                                              |                                | 16b. Kind of Business/Industry<br>Baltimore Gas and Electric                                   |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| 17. Father's Name (First, Middle, Last)<br>James E. McCracken                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    | 18. Mother's Name (First, Middle, Maiden Surname)<br>Helen Hagan                                                                                                                             |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Paulina McCracken-spouse                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8633 Black Oak Rd. Baltimore, Maryland 21234                                                |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                                       |                          |                                                                                                                                                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parkwood Cemetery                                                                                                                                                                                                 |                                                    | Date<br>7/12/00                                                                                                                                                                              |                                | 20c. Location - City or Town, State<br>Baltimore, Maryland                                     |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| 21. Signature of Funeral Service Licensee<br>Heather Cain<br>                                                                                                                                                                                                                                                                           |                                                                                       |                          |                                                                                                                                                        | 22. Name and Address of Facility<br>Leonard J. Ruck, Inc.<br>5305 Harford Road Baltimore, Maryland 21214                                                                                                                                                                                    |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                 |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      | Approximate Interval Between Onset and Death                                                                                            |  |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                           |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      | a. <u>ATHEROSCLEROTIC CORONARY ARTERY DISEASE</u> 4 YEARS                                                                               |  |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      | b. <u>CEREBROVASCULAR DISEASE</u> 2 YEARS                                                                                               |  |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      | c.                                                                                                                                      |  |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      | d.                                                                                                                                      |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>DIABETES MELLITUS</u><br><u>CHRONIC RENAL FAILURE</u>                                                                                                                                                                                                                                        |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                      |                                                                                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                       |                          |                                                                                                                                                        | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                |                                                                                       |                          |                                                                                                                                                        | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                    | 28b. Time of Injury<br>M                                                                                                                                                                     |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |                                                                  | 28d. Describe how injury occurred                                                                                                                                                                |                                                      |                                                                                                                                         |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                    |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                              |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    | 29c. License number<br>D 0035706                                                                                                                                                             |                                | 29d. Date signed (Month, Day, Year)<br>July, 11th, 2000                                        |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>ELIAS GHANDOUR GOOD SAMARITAN Hosp. BALTIMORE, MD                                                                                                                                                                                                                                                                                 |                                                                                       |                          |                                                                                                                                                        |                                                                                                                                                                                                                                                                                             |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                          |                                                                                                                                                        | 32. Registrar's Signature<br>                                                                                                                                                                            |                                                    |                                                                                                                                                                                              |                                |                                                                                                |                                                                  |                                                                                                                                                                                                  |                                                      |                                                                                                                                         |  |



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State of Maryland / Department of Health and Mental Hygiene

00 22388

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                          |                                                                                      |                                                      |                                                                  |                                                                                                                                                        |                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br>Donna McGee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 2. Date of Death<br>Month Day Year<br>July 10, 2000                                                                                                                                                      |                                                                                      |                                                      |                                                                  | 3. Time of Death<br>7:45 PM                                                                                                                            |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br>Genesis ElderCare Center-Homewood                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 4b. City, Town, or Location of Death<br>Baltimore                                                                                                                                                        |                                                                                      |                                                      |                                                                  | 4c. County of Death<br>N/A                                                                                                                             |                                                |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br>214-12-2669                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                              | 7. Age (In yrs. last birthday)<br>77 Yrs.                                                                                                                                                                |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>Nov. 12, 1922 |                                                                  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                                                                                               |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 10b. County<br>N/A                                                                                                                                                                                       |                                                                                      | 10c. City, Town or Location<br>Baltimore             |                                                                  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                     |                                                |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br>6000 Bellona Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 10f. Zip Code<br>21212                                                                                                                                                                                   |                                                                                      | 10g. Citizen of What Country?<br>USA                 |                                                                  |                                                                                                                                                        |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                              | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:         |                                                                                      |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: white |                                                                                                                                                        |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4or 5+) Waitress                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Waitress                                                                                    |                                                                                      |                                                      |                                                                  | 16b. Kind of Business/Industry<br>Restaurant                                                                                                           |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. Father's Name (First, Middle, Last)<br>Russell Martin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br>Pearl Moore                                                                                                                                         |                                                                                      |                                                      |                                                                  |                                                                                                                                                        |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 19a. Informant's Name/Relationship (Type, Print)<br>Darlene Adelsberger Daughter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3823 Roland Avenue Baltimore, Maryland 21211                                                            |                                                                                      |                                                      |                                                                  |                                                                                                                                                        |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Baltimore-Washington Cr.                                                    |                                                                              | 20c. Location - City or Town, State<br>7/14/00 Laurel, Maryland                                                                                                                                          |                                                                                      |                                                      |                                                                  |                                                                                                                                                        |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 22. Name and Address of Facility<br>Burgee-Henss-Seitz Funeral Home, Inc.<br>3631 Falls Road Baltimore, Maryland 21211                                                                                   |                                                                                      |                                                      |                                                                  |                                                                                                                                                        |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>COPD</u><br>Due to (or as a consequence of):<br>b. <u>CHF</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | Approximate Interval Between Onset and Death<br>many years<br>many years                                                                                                                                 |                                                                                      |                                                      |                                                                  |                                                                                                                                                        |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                                                      |                                                      |                                                                  |                                                                                                                                                        |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                              | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                                                      |                                                      |                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                          |                                                                                      |                                                      |                                                                  |                                                                                                                                                        |                                                |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                                                                                                                       | 28b. Time of Injury<br>M                                                     |                                                                                                                                                                                                          | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                      | 28d. Describe how injury occurred                                |                                                                                                                                                        |                                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                                                                                          |                                                                                      |                                                      |                                                                  |                                                                                                                                                        |                                                |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 29b. Signature and title of certifier<br><i>Martha C. Raymond</i>            |                                                                                                                                                                                                          |                                                                                      |                                                      | 29c. License number<br>D54518                                    |                                                                                                                                                        | 29d. Date signed (Month, Day, Year)<br>7-11-00 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>3007 E Northern Parkway Baltimore MD 21214                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 31. Date filed (Month, Day, Year)<br>JUL 14 2000                             |                                                                                                                                                                                                          |                                                                                      |                                                      | 32. Registrar's Signature<br><i>[Signature]</i>                  |                                                                                                                                                        |                                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene 00 22389

## Certificate of Death

Reg. No.

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|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Catherine J. Miller                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                   | 2. Date of Death<br>Month Day Year<br>July 9, 2000                                                                                                                                                |                                                                                                    | 3. Time of Death<br>9:15 PM                                      |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>5306 Valiquet Ave.                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                   | 4b. City, Town, or Location of Death<br>Baltimore City                                                                                                                                            |                                                                                                    | 4c. County of Death<br>N/A                                       |                                                                                                                                                                                                          |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>216-74-6064                                                                                                                                                                                                                                                                                                                                                                                                                                               | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br>62 Yrs.                                                                                                             | If Under 1 Year<br>Months Days                                                                                                                    | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br>April 16, 1938                                              |                                                                  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                   |                                                                                                                                                                                                   |                                                                                                    |                                                                  |                                                                                                                                                                                                          |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 10b. County<br>N/A                                                                                                                                                                                                                                                                                      | 10c. City, Town or Location<br>Baltimore City                                                                                                         |                                                                                                                                                   |                                                                                                                                                                                                   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br>5306 Valiquet Ave.                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 10f. Zip Code<br>21206                                                                                                                            |                                                                                                                                                                                                   | 10g. Citizen of What Country?<br>United States                                                     |                                                                  |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>N/A                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Dependent                                |                                                                                                                                                   | 16b. Kind of Business/Industry<br>N/A                                                                                                                                                             |                                                                                                    |                                                                  |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>Not Known                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Not Known                                                                                                                                    |                                                                                                    |                                                                  |                                                                                                                                                                                                          |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                 | 19a. Informant's Name/Relationship (Type, Print)<br>Dareen Barrios (Caregiver)                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8224 North Boundary Road Dundalk, Maryland 21222 |                                                                                                                                                                                                   |                                                                                                    |                                                                  |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Corp.                                                       |                                                                                                                                                   | Date<br>7/12/2000                                                                                                                                                                                 |                                                                                                    | 20c. Location - City or Town, State<br>Towson, Maryland          |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave. Dundalk, Maryland 21222                             |                                                                                                                                                                                                   |                                                                                                    |                                                                  |                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Myocardial Infarction<br>Due to (or as a consequence of):<br>b. Down's Syndrome<br>Due to (or as a consequence of):<br>c. Seizure Disorder<br>Due to (or as a consequence of):<br>d. Hypothyroidism |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                   |                                                                                                                                                                                                   |                                                                                                    |                                                                  | Approximate Interval Between Onset and Death<br>5 Mins.<br>62 Years<br>5 Years<br>5 Years                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                   |                                                                                                                                                                                                   |                                                                                                    |                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |                                                                                                                                                       |                                                                                                                                                   |                                                                                                                                                                                                   |                                                                                                    |                                                                  |                                                                                                                                                                                                          |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                                                                                                                                   |                                                                                                                                                                                                   |                                                                                                    |                                                                  |                                                                                                                                                                                                          |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                                       | 28b. Time of Injury<br>M                                                                                                                          |                                                                                                                                                                                                   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |                                                                  | 28d. Describe how injury occurred                                                                                                                                                                        |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                                                                                                                       |                                                                                                                                                   |                                                                                                                                                                                                   |                                                                                                    |                                                                  |                                                                                                                                                                                                          |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                   |                                                                                                                                                                                                   |                                                                                                    |                                                                  |                                                                                                                                                                                                          |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 29c. License number<br>D0054034                                                                                                                   |                                                                                                                                                                                                   | 29d. Date signed (Month, Day, Year)<br>July 10, 2000                                               |                                                                  |                                                                                                                                                                                                          |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Meeta Gulati, M.D. 8817 Bel Air Road Baltimore, Maryland 21236                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                                                   |                                                                                                                                                                                                   |                                                                                                    |                                                                  |                                                                                                                                                                                                          |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                                                                                                                       |                                                                                                                                                   |                                                                                                                                                                                                   |                                                                                                    |                                                                  |                                                                                                                                                                                                          |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22390

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                          | 1. Decedent's Name (First, Middle, Last)<br>June Marie Morell                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                               |                                                                                                                                                                                                                                                                                                         |  | 2. Date of Death<br>Month Day Year<br>July 6 2000                                                                                                                                                 |  | 3. Time of Death<br>10:15PM                                                          |  |
|                                                                                                                                                                                                                                                                                                                                            | 4a. Facility Name (If not institution, give street and number)<br>Stella Maris                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               |                                                                                                                                                                                                                                                                                                         |  | 4b. City, Town, or Location of Death<br>Timonium                                                                                                                                                  |  | 4c. County of Death<br>Baltimore                                                     |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                        | 5. Social Security Number<br>173-18-9580                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |  | 7. Age (In yrs. last birthday)<br>83 Yrs.                                                                                                                                                         |  | 8. Date of Birth (Month, Day, Year)<br>June 29 1917                                  |  |
|                                                                                                                                                                                                                                                                                                                                            | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               | 10a. State<br>Md.                                                                                                                                                                                                                                                                                       |  | 10b. County<br>Baltimore                                                                                                                                                                          |  | 10c. City, Town or Location<br>Towson                                                |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                        | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                               | 10e. Street and Number<br>500 Virginia Ave. #601                                                                                                                                                                                                                                                        |  | 10f. Zip Code<br>21286                                                                                                                                                                            |  | 10g. Citizen of What Country?<br>USA                                                 |  |
|                                                                                                                                                                                                                                                                                                                                            | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|                                                                                                                                                                                                                                                                                                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                                                                                                                                  |  | 16b. Kind of Business/Industry<br>Own Home                                                                                                                                                        |  |                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                            | 17. Father's Name (First, Middle, Last)<br>Oliver Schwitzer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                               |                                                                                                                                                                                                                                                                                                         |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Loretta Heilman                                                                                                                              |  |                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                            | 19a. Informant's Name/Relationship (Type, Print)<br>Mr. Thomas Morell/Son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               |                                                                                                                                                                                                                                                                                                         |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>800 Southerly Ct. Towson, Md. 21286                                                              |  |                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                            | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Royal Cemetery                                                                                                                                                                                                            |  | Date<br>7-10-00                                                                                                                                                                                   |  | 20c. Location - City or Town, State<br>Pittsburgh, Pa.                               |  |
|                                                                                                                                                                                                                                                                                                                                            | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                               |                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204                                                                                             |  |                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                            | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Hepatic Carcinoma</u><br>Due to (or as a consequence of):<br>f. _____<br>Due to (or as a consequence of):<br>g. _____<br>Due to (or as a consequence of):<br>h. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>i. _____<br>Due to (or as a consequence of):<br>j. _____ |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                            | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                            | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hypertension</u><br><u>Depression</u><br><u>Alcohol Intoxication</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                            | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                   |  |                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                            | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                |                               | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. Time of Injury<br>M                                                                                                                                                                          |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                            | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               |                                                                                                                                                                                                                                                                                                         |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                      |  |                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  |
| State Registrar                                                                                                                                                                                                                                                                                                                            | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                         |                               |                                                                                                                                                                                                                                                                                                         |  | 29b. Signature and title of certifier<br>                                                                                                                                                         |  | 29c. License number<br>05J283                                                        |  |
|                                                                                                                                                                                                                                                                                                                                            | 29d. Date signed (Month, Day, Year)<br>7/7/00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  |
|                                                                                                                                                                                                                                                                                                                                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>1147 South Howard St Baltimore MD 21200                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 32. Registrar's Signature<br> |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                   |  |                                                                                      |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 22391

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><i>Cordell Maith</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month <i>July</i> Day <i>10</i> Year <i>2000</i>                                                                                                                         |  |                                                                                             |                                                                         | 3. Time of Death<br><i>2 PM</i>                                                                                                                                                                  |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><i>925 Wilmont Ct.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>                                                                                                                                     |  |                                                                                             |                                                                         | 4c. County of Death<br><i>N/A</i>                                                                                                                                                                |  |
| Funeral<br>Director                           | 5. Social Security Number<br><i>213-13-0817</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><i>13</i> Yrs.                                                                                                                                             |  | If Under 1 Year<br>Months Days                                                              |                                                                         | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                   |  |
|                                               | 8. Date of Birth (Month, Day, Year)<br><i>July 30, 1986</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 9. Birthplace (State or Foreign Country)<br><i>Maryland</i>                                                                                                                                                                                                                                 |  | Usual Residence of Decedent                                                                                                                                                                  |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
| To Be Completed by Funeral Director           | 10a. State<br><i>Maryland</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10b. County<br><i>N/A</i>                                                                                                                                                                                                                                                                   |  | 10c. City, Town or Location<br><i>Baltimore</i>                                                                                                                                              |  |                                                                                             |                                                                         | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |  |
|                                               | 10a. Street and Number<br><i>925 Wilmont Ct.</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 10f. Zip Code<br><i>21202</i>                                                                                                                                                                |  | 10g. Citizen of What Country?<br><i>U. S. A.</i>                                            |                                                                         |                                                                                                                                                                                                  |  |
|                                               | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i> |                                                                                                                                                                                                  |  |
|                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>7</i> College (1-4or 5+) <i>0</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Student</i>                                                                                                                                                                 |  |                                                                                                                                                                                              |  | 16b. Kind of Business/Industry<br><i>School</i>                                             |                                                                         |                                                                                                                                                                                                  |  |
| To Be Completed by Funeral Director           | 17. Father's Name (First, Middle, Last)<br><i>William A. Laws</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Jacqueline Maith</i>                                                                                                                 |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
|                                               | 19a. Informant's Name/Relationship (Type, Print) (Mother)<br><i>Ms. Jacqueline Maith</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>925 Wilmont Ct. Balto. Md. 21202</i>                                                     |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
|                                               | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Western Cemetery</i>                                                                                                                                                                                           |  | 20c. Location - City or Town, State<br><i>Balto. Md.</i>                                                                                                                                     |  | 20d. Date<br><i>7/17/2000</i>                                                               |                                                                         |                                                                                                                                                                                                  |  |
|                                               | 21. Signature of Funeral Service Licensee<br><i>Joseph L. Russ</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 22. Name and Address of Facility<br><i>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto. Md. 21216</i>                                                                               |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>Medulloblastoma</i><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         | Approximate Interval Between Onset and Death<br><i>4 years</i>                                                                                                                                   |  |
|                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |  |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
|                                               | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                            |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. Time of Injury<br><i>M</i>                                                                                                                                                              |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                         | 28d. Describe how injury occurred                                                                                                                                                                |  |
|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |  |
|                                               | 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
| State Registrar                               | 29b. Signature and title of certifier<br><i>Kaveri Suryanarayan MD</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 29c. License number<br><i>D0055194</i>                                                                                                                                                       |  |                                                                                             |                                                                         | 29d. Date signed (Month, Day, Year)<br><i>7/12/00</i>                                                                                                                                            |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Kaveri Suryanarayan MD 225 South Greene St Rm N5216 Baltimore MD 21201</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                              |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><i>JUL 14 2000</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 32. Registrar's Signature<br><i>Benita B Sparks</i>                                                                                                                                          |  |                                                                                             |                                                                         |                                                                                                                                                                                                  |  |

ORIGINAL



00-3668-005

cm

Baby Girl Norton

AMEND ITEMS: #1, 23 PART I, 27, 28A-F PER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

MEO G-786.8-1-00 WR. Certificate of Death

Reg. No.

00 22392

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0028.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                  |                                            |                                                                                                                                                                                                                                                                                          |                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>SARAH MARY NORTON</b>                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 2. Date of Death<br>Month <b>July</b> Day <b>04</b> Year <b>2000</b>                                                                                                                             |                                            | 3. Time of Death<br><b>7:00 A.M.</b>                                                                                                                                                                                                                                                     |                                                             |
| 4a. Facility Name (If not institution, give street and number)<br><b>Greater Baltimore Medical Center</b>                                                                                                                                                                                                                                                                                                                 |                                                                            | 4b. City, Town, or Location of Death<br><b>Towson</b>                                                                                                                                            |                                            | 4c. County of Death<br><b>Baltimore</b>                                                                                                                                                                                                                                                  |                                                             |
| 5. Social Security Number<br><b>None</b>                                                                                                                                                                                                                                                                                                                                                                                  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>Yrs. _____                                                                                                                                                     | If Under 1 Year<br>Months _____ Days _____ | 8. Date of Birth (Month, Day, Year)<br><b>July 4, 2000</b>                                                                                                                                                                                                                               | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | 10c. City, Town or Location                                                                                                                                                                      |                                            | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                           |                                                             |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                             | 10b. County<br><b>Baltimore</b>                                            | 10c. City, Town or Location<br><b>Towson</b>                                                                                                                                                     |                                            | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                           |                                                             |
| 10e. Street and Number<br><b>936 Beaverbank Circle</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                                            | 10f. Zip Code<br><b>21286</b>                                                                                                                                                                    |                                            | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                              |                                                             |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                |                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                             |                                                             |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) _____                                                                |                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>None</b>                                                                                                                                                                 |                                                             |
| 16b. Kind of Business/Industry<br><b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                              |                                                                            | 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>                                                                                                                                        |                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Kelly Elizabeth Norton</b>                                                                                                                                                                                                       |                                                             |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Kelly Elizabeth Norton Mother</b>                                                                                                                                                                                                                                                                                                                                  |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>936 Beaverbank Circle Towson, Maryland 21286</b>                                             |                                            |                                                                                                                                                                                                                                                                                          |                                                             |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St Mary's Cemetery</b>                                                                                              |                                            | 20c. Location - City or Town, State<br><b>7/7/00 Baltimore, Maryland</b>                                                                                                                                                                                                                 |                                                             |
| 21. Signature of Funeral Service Licensee<br><i>Dennis Stephen Kenaka</i>                                                                                                                                                                                                                                                                                                                                                 |                                                                            | 22. Name and Address of Facility<br><b>Mitchell-Wiedefeld Funeral Home Inc.<br/>6500 York Road Baltimore, Maryland 21212</b>                                                                     |                                            |                                                                                                                                                                                                                                                                                          |                                                             |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>SUFFOCATION</b>                                                                                                                                                                                       |                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                            | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                    |                                                             |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                        |                                                                            | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                |                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                             |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined                                                                                                                                                |                                                                            | 28a. Date of Injury (Month, Day, Year)<br><b>7-4-00</b>                                                                                                                                          |                                            | 28b. Time of Injury<br><b>6:30 M</b>                                                                                                                                                                                                                                                     |                                                             |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                            | 28d. Describe how injury occurred<br><b>SUBJECT WAS ASPHYXIATED</b>                                                                                                                              |                                            | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>936 BEAVER BANK CIRCLE, TOWSON, MD.</b>                                                                                                                                                               |                                                             |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                            | 29b. Signature and title of certifier<br><i>Mary G. Rippler M.D.</i>                                                                                                                             |                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                   |                                                             |
| 29d. Date signed (Month, Day, Year)<br><b>July 05, 2000</b>                                                                                                                                                                                                                                                                                                                                                               |                                                                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARY G. RIPPLER M.D. 111 Penn Street, Baltimore, Maryland 21201</b>                                   |                                            | 31. Data filed (Month, Day, Year)<br><b>AUG 01 2000</b>                                                                                                                                                                                                                                  |                                                             |
| 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                                  |                                            |                                                                                                                                                                                                                                                                                          |                                                             |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22393

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Dove Olsen

2. Date of Death

Month Day Year  
July 12 2000

3. Time of Death

12:24 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Hospice House of the Chesapeake

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

Anne Arundel

5. Social Security Number

214-30-3429

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 4, 1910

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

738 Match Point Drive

10f. Zip Code

21012

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Income Tax Supervisor

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

William Dove

18. Mother's Name (First, Middle, Maiden Summa)

Susie Virginia Brown

19a. Informant's Name/Relationship (Type, Print)

Ellen V. Foxwell (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

738 Match Point Drive, Arnold, MD 21012

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baldwin Cemetery

Date

07/17  
2000

20c. Location - City or Town, State

Millersville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Carcinoma of Pancreas

Approximate Interval Between Onset and Death

1 month

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

Deep Vein Thrombophlebitis

Arteriosclerotic Cardiovascular Disease

Old Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Home

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D14160

29d. Date signed (Month, Day, Year)

07/12/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature



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State of Maryland / Department of Health and Mental Hygiene

00 22394

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Stephen M. O'Connell, Jr.

2. Date of Death

Month Day Year  
JULY 6 2000

3. Time of Death

12:40 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

5. Social Security Number

213-03-0613

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

8. Date of Birth (Month, Day, Year)

Mar. 8, 1914

9. Birthplace (State or Foreign Country)

Md.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

205 E. Joppa Rd. #705

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Self Employed

16b. Kind of Business/Industry

Paving Cont.

17. Father's Name (First, Middle, Last)

Stephen M. O'Connell, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Louise P. Schaudron

19a. Informant's Name/Relationship (Type, Print)

Mrs. Mary E. O'Connell/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

205 E. Joppa Rd. #705 Towson, Md. 21204

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial

Date

7/8/00

20c. Location - City or Town, State

Timonium, Md.

21. Signature of Funeral Service licensee

22. Name and Address of Facility

Ruck Towson Funeral Home, Inc.  
1050 York Rd. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiogenic shock

Due to (or as a consequence of):

b. Myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Coronary artery disease

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RONALD D SCHECHTER, MD 6565 N. Charles St. Suite 615 Baltimore, MD 21204

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

[Signature]

State Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22395

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DONNEL

PINKNEY

2. Date of Death

July

Day

9 2000

Year

22:45

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

The Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

190-38-9909

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

March 12, 1947

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

PA

10b. County

Lancaster

10c. City, Town or Location

Lancaster, PA

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

505 Locust Street

10f. Zip Code

17602

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

Unk.

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Steel Worker

16b. Kind of Business/Industry

Lukens Steel Company

17. Father's Name (First, Middle, Last)

James Pinkney

18. Mother's Name (First, Middle, Maiden Surname)

Louise Jenkin

19a. Informant's Name/Relationship (Type, Print)

Mary Pinkney / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

505 Locust Street, Lancaster, PA 17602

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mallingers Mennonite Cemetery July 14, 2000 Lancaster, PA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee Victor P. Doda, Jr.

[Signature]

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.  
1501 East Fort Avenue, Baltimore Maryland 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOMYOPATHY; IDIOPATHIC

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

July 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JENNIFOR MUIERS MD 600 N WILF ST NELSON 106 BALTIMORE, MD 21287

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**

State of Maryland / Department of Health and Mental Hygiene

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

David L. Pearce

2. Date of Death

Month Day Year  
JULY 03, 2000

3. Time of Death

20:14 PM

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

218-80-9088

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

40

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 11, 1960

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2443 Westport St.

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Private Company

17. Father's Name (First, Middle, Last)

Roosevelt Pearce Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Hazel Marie Stowe

19a. Informant's Name/Relationship (Type, Print) (Sister)

Ms. Barbara Pearce

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2001 N. Hilton St. Floor Balto. Md. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion

Date

7/19/2000

20c. Location - City or Town, State

Lansdowne, Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ALCOHOL AND NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☒ Could not be determined

28a. Date of Injury

Month, Day Year  
FOUND: 7/3/00

28b. Time of Injury

FOUND: 7:27 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

RESIDENCE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

BALTIMORE, MD 2443 WESTPORT STREET,

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JULY 04, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Theodore M. King

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

Theodore M. King

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

101 JUL 1 1961

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22397

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLIE

2. Date of Death

July 9, 2000

3. Time of Death

2:30 AM

4a. Facility Name (If not institution, give street and number)

MERCY AT STELLA MARIS HOSPICE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

247-62-3781

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs, last birthday)

61 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

MARCH 2, 1939

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3706 LAMOINE ROAD

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

STEEL WORKER

16b. Kind of Business/Industry

JORGENSEN STEEL CO.

17. Father's Name (First, Middle, Last)

WASH

18. Mother's Name (First, Middle, Maiden Summa)

RICHBURG

BERNICE

RHAMES

19a. Informant's Name/Relationship (Type, Print)

SANDRA RHAMES (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3706 LAMOINE ROAD, RANDALLSTOWN, MD. 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

ARBUTUS CEMETERY

Date

7-15-00

20c. Location - City or Town, State

ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME  
2140 N. FULTON AVE., BALTO. MD. 2121723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Metastatic Small Cell Lung Cancer  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Squamous Cell Carcinoma of Esophagus  
Prostate Cancer  
Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D40854

29d. Date signed (Month, Day, Year)

July 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID RISEBERG

301 St Paul Pl

BALTIMORE, MD 21202

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2025.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22398

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                       |                                                              |                                                                                                                                                                                                         |                                                             |                                                                                                                                                                                                                 |                                                                                                           |                                                               |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM FRANK REARDON</b>                     |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                       |                                                              |                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br><b>July 6, 2000</b>   |                                                                                                                                                                                                                 | 3. Time of Death<br><b>9:30 PM</b>                                                                        |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4a. Facility Name (If not institution, give street and number)<br><b>College Manor, Inc.</b> |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                       |                                                              |                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>Lutherville</b>  |                                                                                                                                                                                                                 | 4c. County of Death<br><b>Baltimore</b>                                                                   |                                                               |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 5. Social Security Number<br><b>171-10-9620</b>                                              |  | 6. Sex<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>                                                                        |                                                                                                                                                                                                                                                                                                                       | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs. Months Days |                                                                                                                                                                                                         | 8. Date of Birth (Month, Day, Year)<br><b>Apr. 11, 1910</b> |                                                                                                                                                                                                                 | 9. Birthplace (State or Foreign Country)<br><b>MA.</b>                                                    |                                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Usual Residence of Decedent                                                                  |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                       |                                                              |                                                                                                                                                                                                         |                                                             |                                                                                                                                                                                                                 |                                                                                                           |                                                               |  |
| 10a. State<br><b>N.H.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                              |  | 10b. County<br><b>Rockingham</b>                                                                                                                             |                                                                                                                                                                                                                                                                                                                       |                                                              | 10c. City, Town or Location<br><b>Portsmouth</b>                                                                                                                                                        |                                                             |                                                                                                                                                                                                                 | 10d. Inside City Limits<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b> |                                                               |  |
| 10e. Street and Number<br><b>183 Coolidge Dr.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                       |                                                              | 10f. Zip Code<br><b>03801</b>                                                                                                                                                                           |                                                             | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                     |                                                                                                           |                                                               |  |
| 11. Marital Status<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b><br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                                       |                                                              | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:</b> |                                                             |                                                                                                                                                                                                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                   |                                                               |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b> Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |  |                                                                                                                                                              | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Naval Architect</b>                                                                                                                                                                                   |                                                              |                                                                                                                                                                                                         |                                                             | 16b. Kind of Business/Industry<br><b>Federal Government</b>                                                                                                                                                     |                                                                                                           |                                                               |  |
| 17. Father's Name (First, Middle, Last)<br><b>William Reardon</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                       |                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Katherine MacCauley</b>                                                                                                                         |                                                             |                                                                                                                                                                                                                 |                                                                                                           |                                                               |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Edward Reardon/son</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                       |                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8406 Gerogian Way Annandale, Va. 22003</b>                                                          |                                                             |                                                                                                                                                                                                                 |                                                                                                           |                                                               |  |
| 20a. Method of Disposition<br><b>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              |  |                                                                                                                                                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>                                                                                                                                                                                                                |                                                              | Date<br><b>7/8/00</b>                                                                                                                                                                                   |                                                             | 20c. Location - City or Town, State<br><b>Towson, Md.</b>                                                                                                                                                       |                                                                                                           |                                                               |  |
| 21. Signature of Funeral Service Licenses<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                       |                                                              | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>                                                                                           |                                                             |                                                                                                                                                                                                                 |                                                                                                           |                                                               |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death) <b>a. cerebrovascular accident</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. {</b><br>Due to (or as a consequence of):<br><br><b>c. {</b><br>Due to (or as a consequence of):<br><br><b>d. {</b> |                                                                                              |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                       |                                                              |                                                                                                                                                                                                         |                                                             |                                                                                                                                                                                                                 |                                                                                                           | Approximate Interval Between Onset and Death<br><b>3 days</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's disease</b><br><b>benign prostatic hypertrophy</b><br><b>cystitis</b>                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                       |                                                              |                                                                                                                                                                                                         |                                                             | 23b. Did tobacco use contribute to the cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown</b> |                                                                                                           |                                                               |  |
| 24a. Was an autopsy performed?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |  |                                                                                                                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</b>                                                                                                                                                                    |                                                              |                                                                                                                                                                                                         |                                                             |                                                                                                                                                                                                                 |                                                                                                           |                                                               |  |
| 25. Was case referred to medical examiner?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                              |  |                                                                                                                                                              | 26. Place of Death (Check only one)<br>Hospital: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> Other: <b>4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b> |                                                              |                                                                                                                                                                                                         |                                                             |                                                                                                                                                                                                                 |                                                                                                           |                                                               |  |
| 27. Manner of Death<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                              |  |                                                                                                                                                              | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                |                                                              | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                         |                                                             | 28c. Injury at Work?<br><b>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</b>                                                                                                          |                                                                                                           | 28d. Describe how injury occurred                             |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |  |                                                                                                                                                              | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                          |                                                              |                                                                                                                                                                                                         |                                                             |                                                                                                                                                                                                                 |                                                                                                           |                                                               |  |
| 29a. Certifier (Check only one)<br><b>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>                                                                                                                                                                                                            |                                                                                              |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                       |                                                              |                                                                                                                                                                                                         |                                                             |                                                                                                                                                                                                                 |                                                                                                           |                                                               |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                              |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                       |                                                              | 29c. License number<br><b>D24121</b>                                                                                                                                                                    |                                                             | 29d. Date signed (Month, Day, Year)<br><b>7/7/00</b>                                                                                                                                                            |                                                                                                           |                                                               |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BRUCE ROSENBERG 21 WEST RD TOWSON, MD 21204</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              |  |                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                       |                                                              |                                                                                                                                                                                                         |                                                             |                                                                                                                                                                                                                 |                                                                                                           |                                                               |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              |  |                                                                                                                                                              | 32. Registrar's Signature<br>                                                                                                                                                                                                      |                                                              |                                                                                                                                                                                                         |                                                             |                                                                                                                                                                                                                 |                                                                                                           |                                                               |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22399

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Paul Runk, Jr.

2. Date of Death

Month Day Year  
July 11, 2000

3. Time of Death

7:45 PM

4a. Facility Name (If not institution, give street and number)

2910 Delmar Avenue

4b. City, Town, or Location of Death

Edgemere

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

N/A

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 27, 2000

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2910 Delmar Avenue

10f. Zip Code

21219

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Dependent

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Richard Paul Runk, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Amberly Dawn White

19a. Informant's Name/Relationship (Type, Print) (Father)

Mr. Richard P. Runk, Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2910 Delmar Avenue Edgemere, Maryland 21219

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hilltop Service Corp.

Date

7/14/2000

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Trisomy 13

Due to (or as a consequence of):

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D0040362

29d. Date signed (Month, Day, Year)

July 12, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Thomas P. O'Brien, M.D. Sinai Hospital

2401 W. Belvedere Ave.

Baltimore, Md 21215

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Richard Runk, Jr.



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State of Maryland / Department of Health and Mental Hygiene

00 22400

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                   |                           |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|---------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1. Decedent's Name (First, Middle, Last)<br><b>John R. Rickard</b>                                                |                           |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <b>07</b> Day <b>11</b> Year <b>2000</b>                                                                                                                            |                                 |                                                      |                                                                                                | 3. Time of Death<br><b>2:00 pm</b>                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4a. Facility Name (If not institution, give street and number)<br><b>VA MEDICAL CENTER, FORT HOWARD, MARYLAND</b> |                           |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>FORT HOWARD</b>                                                                                                                                    |                                 |                                                      |                                                                                                | 4c. County of Death<br><b>BALTIMORE</b>                     |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 5. Social Security Number<br><b>216-36-2545</b>                                                                   |                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                 |                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>65</b> Yrs.                                                                                                                                              |                                 | 8. Date of Birth (Month, Day, Year)<br><b>7/3/35</b> |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Usual Residence of Decedent                                                                                       |                           |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   | 10b. County<br><b>N/A</b> |                                                                                                                                                                            | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                 |                                                      | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                             |  |
| 10e. Street and Number<br><b>16A W. 23rd Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                   |                           |                                                                                                                                                                            | 10f. Zip Code<br><b>21218</b>                                                                                                                                                                                                                                                               |                                                                                                                                                                                               |                                 |                                                      | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                             |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1954</b><br>If Yes, Give Year or Dates: <b>KOREA</b> |                                                                                                                                                                                                                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                 |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                   |                           |                                                                                                                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Unknown</b>                                                                                                                                                                 |                                                                                                                                                                                               |                                 |                                                      | 16b. Kind of Business/Industry<br><b>Unknown</b>                                               |                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>Fred Rickard</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                   |                           |                                                                                                                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances Kalbarczyk</b>                                                                                                                                                                                                              |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Susan Guerchio/Step-Sister</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   |                           |                                                                                                                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2228 Battery Park Road, Chesapeake VA. 23323</b>                                                                                                                                        |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   |                           |                                                                                                                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>                                                                                                                                                                                            |                                                                                                                                                                                               | Date<br><b>7/14/00</b>          |                                                      | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                              |                                                             |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                   |                           |                                                                                                                                                                            | 22. Name and Address of Facility<br><b>David J. Weber Funeral Homes, P.A.<br/>401 S. Chester St. Baltimore, Maryland 21231</b>                                                                                                                                                              |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Abdominal Cancer, exact nature not known</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br><b>two months</b> |                                                                                                                   |                           |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                   |                           |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   |                           |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                   |                           |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Morbid Obesity, Hypertension,<br/>Gallstones,<br/>Depression</b>                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                   |                           |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                   |                           |                                                                                                                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                       |                                                                                                                   |                           |                                                                                                                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                                                               | 28b. Time of Injury<br><b>M</b> |                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |                                                             |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   |                           |                                                                                                                                                                            | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   |                           |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                           |                                                                                                                   |                           |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                   |                           |                                                                                                                                                                            | 29c. License number<br><b>D14958</b>                                                                                                                                                                                                                                                        |                                                                                                                                                                                               |                                 |                                                      | 29d. Date signed (Month, Day, Year)<br><b>July 11, 2000</b>                                    |                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Aurora C. Tan, M.D. 9600 North Point Road, Fort Howard, MD 21052</b>                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                   |                           |                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                   |                           |                                                                                                                                                                            | 32. Registrar's Signature<br>                                                                                                                                                                            |                                                                                                                                                                                               |                                 |                                                      |                                                                                                |                                                             |  |

Decedent: JOHN R. RICKARD  
Baltimore, Maryland 21215-0020Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



00 2240

ORIGINAL





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

amend item 23a,b per phys. G785 7/14/00 yg State of Maryland / Department of Health and Mental Hygiene

00 22402

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                  |                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                       | 1. Decedent's Name (First, Middle, Last)<br><b>Lorraine M. Smith</b>                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             | 2. Date of Death<br>Month Day Year<br><b>JULY 12 2000</b>                                                                                                                                    |                                                                                                | 3. Time of Death<br><b>6:29 AM</b>                                                                                                                                                               |                                                                                                                                         |
|                                                                                                                                                                                                                                                                         | 4a. Facility Name (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b>                                                                                                                                           |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                                                                                                                     |                                                                                                | 4c. County of Death<br><b>N/A</b>                                                                                                                                                                |                                                                                                                                         |
| Funeral<br>Director                                                                                                                                                                                                                                                     | 5. Social Security Number<br><b>216-40-0908</b>                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.            | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                                                                 | 8. Date of Birth (Month, Day, Year)<br><b>MAY 29 1942</b>                                                                                                                                        | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                                                                   |
|                                                                                                                                                                                                                                                                         | Usual Residence of Decedent                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                  |                                                                                                                                         |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                     | 10a. State<br><b>MD</b>                                                                                                                                                                                                               | 10b. County<br><b>NA</b>                                                                                                                                                                                                                                                                                  | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                   |                                                             |                                                                                                                                                                                              | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                  |                                                                                                                                         |
|                                                                                                                                                                                                                                                                         | 10e. Street and Number<br><b>3709 W. FOREST PARK AVE</b>                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   | 10f. Zip Code<br><b>21216</b>                               |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                                                                                                                                                                  |                                                                                                                                         |
|                                                                                                                                                                                                                                                                         | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                        |                                                                                                                                                                                                                                                                                                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>African American</b>                                                                                                               |                                                                                                                                         |
|                                                                                                                                                                                                                                                                         | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>2</b>                                                                                               |                                                                                                                                                                                                                                                                                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>COOK</b>                          |                                                             | 16b. Kind of Business/Industry<br><b>RESTAURANT</b>                                                                                                                                          |                                                                                                |                                                                                                                                                                                                  |                                                                                                                                         |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                           | 17. Father's Name (First, Middle, Last)<br><b>Sylvester Tucker</b>                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jenny Smith</b>                                                                                                                      |                                                                                                |                                                                                                                                                                                                  |                                                                                                                                         |
|                                                                                                                                                                                                                                                                         | 19a. Informant's Name/Relationship (Type, Print)<br><b>THOMAS J. SMITH Brother</b>                                                                                                                                                    |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8840 HARKATE WAY RANDALLSTOWN, MD 21133</b>                                              |                                                                                                |                                                                                                                                                                                                  |                                                                                                                                         |
|                                                                                                                                                                                                                                                                         | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                                                                                                                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT ZION CEMETERY</b>                                                 |                                                             | 20c. Location - City or Town, State<br><b>Landdown, MD</b>                                                                                                                                   |                                                                                                | 20d. Date<br><b>7/17/00</b>                                                                                                                                                                      |                                                                                                                                         |
|                                                                                                                                                                                                                                                                         | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             | 22. Name and Address of Family<br><b>Wayne Eugene Thompson 638 N. Selma St. Balt. MD 21217</b>                                                                                               |                                                                                                |                                                                                                                                                                                                  |                                                                                                                                         |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                       | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                  | Approximate Interval Between Onset and Death                                                                                            |
|                                                                                                                                                                                                                                                                         | Immediate Cause (Final disease or condition resulting in death)<br><b>a. LUNG CANCER</b>                                                                                                                                              |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                  | <b>UNKNOWN</b>                                                                                                                          |
|                                                                                                                                                                                                                                                                         | Due to (or as a consequence of):<br><b>METASTATIC LUNG CANCER</b>                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                  |                                                                                                                                         |
|                                                                                                                                                                                                                                                                         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>d. METASTATIC LUNG CANCER</b>                                        |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                  | <b>UNKNOWN</b>                                                                                                                          |
| Due to (or as a consequence of):                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                  |                                                                                                                                         |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                  |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             |                                                                                                                                                                                              |                                                                                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                                                                                                         |
|                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             |                                                                                                                                                                                              |                                                                                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                       |                                                                                                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)               |                                                                                                                                                   |                                                             |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                  |                                                                                                                                         |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |                                                                                                                                                                                                                                       | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                    |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>                             |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |                                                                                                                                                                                                  | 28d. Describe how injury occurred                                                                                                       |
|                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                    |                                                                                                                                                   |                                                             |                                                                                                                                                                                              | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |                                                                                                                                                                                                  |                                                                                                                                         |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner                                                                                                                                                                                 |                                                                                                                                                                                                                                       | 29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                   |                                                             |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                  |                                                                                                                                         |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                               |                                                                                                                                                                                                                                       | 29c. License number<br><b>P19600</b>                                                                                                                                                                                                                                                                      |                                                                                                                                                   | 29d. Date signed (Month, Day, Year)<br><b>JULY 12, 2000</b> |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                  |                                                                                                                                         |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>NASSER NASERTASH 900 CATON AVE BALTIMORE MD 21229</b>                                                                                                                        |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                           |                                                                                                                                                   |                                                             |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                  |                                                                                                                                         |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                 |                                                                                                                                                                                                                                       | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                             |                                                                                                                                                                                              |                                                                                                |                                                                                                                                                                                                  |                                                                                                                                         |



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State of Maryland / Department of Health and Mental Hygiene

00 22403

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                                  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>DALLAS STANLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | 2. Date of Death<br>Month Day Year<br><b>JULY, 8, 2000</b>                                                                                                                                                                                                                                  |                                      | 3. Time of Death<br><b>8:34 PM</b>                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                                                                                                                                                                                                                    |                                      | 4c. County of Death<br><b>N/A</b>                                                                                                                                                                |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>231-32-9759</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F     | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.                                                                                                                                                                                                                                            | If Under 1 Year<br>Months Days       | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><b>MARCH 19, 1929</b>                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                | 9. Birthplace (State or Foreign Country)<br><b>VIRGINIA</b>                                                                                                                                                                                                                                 |                                      |                                                                                                                                                                                                  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 10b. County<br><b>ANNE ARUNDEL</b>                                             | 10c. City, Town or Location<br><b>SEVERN</b>                                                                                                                                                                                                                                                |                                      | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>103 DENSON DRIVE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | 10f. Zip Code<br><b>21144</b>                                                                                                                                                                                                                                                               |                                      | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                  |                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1947-1968</b>                                                                                                                          |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>                                                                                                                                                 |                                      |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STAFF SERGEANT</b>                                                                                                                                                                                                                                                                                                                                                              |                                                                                | 16b. Kind of Business/Industry<br><b>U.S. ARMY</b>                                                                                                                                                                                                                                          |                                      |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. Father's Name (First, Middle, Last)<br><b>JAMES STANLEY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>FRANCES FLEMING</b>                                                                                                                                                                                                                 |                                      |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>MRS. KATHARINA STANLEY (WIFE)</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>103 DENSON DRIVE, SEVERN, MARYLAND 21144</b>                                                                                                                                            |                                      |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                           |                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND VETERANS CEMETERY</b>                                                                                                                                                                                 |                                      | 20c. Location - City or Town, State<br><b>CROWNSVILLE, MD.</b>                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br><b>B. J. Clyne M01138</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MARYLAND 21061</b>                                                                                                                                                             |                                      |                                                                                                                                                                                                  |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cerebrovascular accident</b><br>Due to (or as a consequence of):<br><b>b. SEIZURES</b><br>Due to (or as a consequence of):<br><b>c. PNEUMOTHORAX</b><br>Due to (or as a consequence of):<br><b>d.</b> |                                                                                |                                                                                                                                                                                                                                                                                             |                                      | Approximate Interval Between Onset and Death<br><b>1 year</b><br><b>6 DAYS</b><br><b>2 DAYS</b>                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CORONARY ARTERY DISEASE</b>                                                                                                                                                                                                                                                                                                                                   |                                                                                |                                                                                                                                                                                                                                                                                             |                                      | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                             | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                      |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                               |                                                                                | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                      |                                                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                         |                                                                                | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                      | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                      |                                                                                                                                                                                                  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 29b. Signature and title of certifier<br><b>Dr. SRIKANTH RAMACHANDRAN PGY2</b> |                                                                                                                                                                                                                                                                                             | 29c. License number<br><b>P13132</b> | 29d. Date signed (Month, Day, Year)<br><b>JULY 8, 2000</b>                                                                                                                                       |
| 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>Dr. SRIKANTH RAMACHANDRAN HARBOR HOSPITAL CENTER<br/>BALTIMORE MD 21225</b>                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                        |                                                                                                                                                                                                                                                                                             |                                      |                                                                                                                                                                                                  |

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State of Maryland / Department of Health and Mental Hygiene

00 22404

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO C-785-7-26-00 WR

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                          |                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                             |                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1. Decedent's Name (First, Middle, Last)<br><b>BETTY RUTH SAWYER</b>                     |                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                               | 2. Date of Death<br>Month <b>JULY</b> Day <b>11</b> Year <b>2000</b> |                                                                                                                                                                                                             | 3. Time of Death<br><b>19:21 PM</b>                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4a. Facility Name (If not institution, give street and number)<br><b>331 POPLAR ROAD</b> |                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                               | 4b. City, Town, or Location of Death<br><b>MILLERSVILLE</b>          |                                                                                                                                                                                                             | 4c. County of Death<br><b>ANNE ARUNDEL</b>                 |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5. Social Security Number<br><b>407-22-2774</b>                                          |                                                                                                                                                                                                                                                                                                          | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                               | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.                     |                                                                                                                                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 7, 1926</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 9. Birthplace (State or Foreign Country)<br><b>KENTUCKY</b>                              |                                                                                                                                                                                                                                                                                                          | 10a. State<br><b>MARYLAND</b>                                              |                                                                                                                                                                                               | 10b. County<br><b>ANNE ARUNDEL</b>                                   |                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>MILLERSVILLE</b>         |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                          | 10e. Street and Number<br><b>331 POPLAR ROAD</b>                                                                                                                                                                                                                                                         |                                                                            | 10f. Zip Code<br><b>21108</b>                                                                                                                                                                 |                                                                      | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                              |                                                            |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                         |                                                                                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                        |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                     |                                                            |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b><br>College (1-4or 5+) <b>College (1-4or 5+)</b>                                                                                                                                                                                                                                                                                                                                |                                                                                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>RURAL CARRIER</b>                                                                                                                                                                        |                                                                            | 16b. Kind of Business/Industry<br><b>U. S. GOVERNMENT</b>                                                                                                                                     |                                                                      |                                                                                                                                                                                                             |                                                            |  |
| 17. Father's Name (First, Middle, Last)<br><b>HENRY BOGGS</b>                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                          |                                                                                                                                                                                                                                                                                                          |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>CORA LEE MORRIS</b>                                                                                                                   |                                                                      |                                                                                                                                                                                                             |                                                            |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ROBERT SAWYER, SR. (HUSBAND)</b>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          |                                                                                                                                                                                                                                                                                                          |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>331 POPLAR ROAD, MILLERSVILLE, MARYLAND 21108</b>                                         |                                                                      |                                                                                                                                                                                                             |                                                            |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                  |                                                                                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN MEMORIAL PARK</b>                                                                                                                                                                                                |                                                                            | Date<br><b>JULY 15, 2000</b>                                                                                                                                                                  |                                                                      | 20c. Location - City or Town, State<br><b>GLEN BURNIE, MD.</b>                                                                                                                                              |                                                            |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                        |                                                                                          | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A.,<br/>1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>                                                                                                                                                                               |                                                                            |                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                             |                                                            |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>MULTIPLE INJURIES</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b> |                                                                                          | a. Due to (or as a consequence of):                                                                                                                                                                                                                                                                      |                                                                            | b. Due to (or as a consequence of):                                                                                                                                                           |                                                                      | c. Due to (or as a consequence of):                                                                                                                                                                         |                                                            |  |
| d. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                          |                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                             |                                                            |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                 |                                                                                          |                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                               |                                                                      | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                            |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                          |                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                               |                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                            |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                      |                                                                                          | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |                                                                            |                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                             |                                                            |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                |                                                                                          | 28a. Date of Injury (Month, Day, Year)<br><b>7-11-00</b>                                                                                                                                                                                                                                                 |                                                                            | 28b. Time of Injury<br><b>7:14 M</b>                                                                                                                                                          |                                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                 |                                                            |  |
| 28d. Describe how injury occurred<br><b>EXPLODED DUE TO A PROPANE GAS LEAK</b>                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                          | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>RESIDENCE</b>                                                                                                                                                                                               |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>331 POPLAR RD. MILLERSVILLE, MD</b>                                                                        |                                                                      |                                                                                                                                                                                                             |                                                            |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                           |                                                                                          | 29b. Signature and title of certifier<br>                                                                                                                                                                             |                                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                        |                                                                      | 29d. Date signed (Month, Day, Year)<br><b>JULY 12, 2000</b>                                                                                                                                                 |                                                            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARY G. RIPLEY, M.D., 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                        |                                                                                          |                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                             |                                                            |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                          | 32. Registrar's Signature<br>                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                               |                                                                      |                                                                                                                                                                                                             |                                                            |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22405

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James K. Shores

2. Date of Death  
Month Day Year

July 11 2000 11:31 PM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

217-20-6009

6. Sex

10 M 2 F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

Nov. 20, 1925

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Parkville

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

9B Mopec Circle

10f. Zip Code

21236

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Printer

16b. Kind of Business/Industry

Newspaper

17. Father's Name (First, Middle, Last)

Robert Lee Shores

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Kelly

19a. Informant's Name/Relationship (Type, Print)

Mrs. Gladys O. Shores - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9B Mopec Circle Baltimore, Maryland 21236

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith

Date

7/15/2000 Baltimore, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee Michael E. Canapp

Michael E. Canapp

22. Name and Address of Facility

LEONARD J. RUCK, INC. Baltimore, MD 21214

5305 Harford Road

Physician  
/Medical  
Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intracranial Hemorrhage

Due to (or as a consequence of):

b. Coagulopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 Hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

26. Place of Death (Check only one)

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

SANJU VARGHESE M.D.

29c. License number

RD 203323

29d. Date signed (Month, Day, Year)

7/11/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Sanju Varghese 9000 Franklin Square Drive Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

Benjamin Sparks

State  
Registrar

ORIGINAL

SHORES, JAMES  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2000.

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22406

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                                |                                             |                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1. Decedent's Name (First, Middle, Last)<br><b>John Francis Sheska</b>                                    |                                                                                                                                                                |                                             |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>July 9, 2000</b>       |                                                                                                                                                                                                  | 3. Time of Death<br><b>12:00 am</b>                                                            |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4a. Facility Name (If not institution, give street and number)<br><b>Genesis Eldercare Franklin Woods</b> |                                                                                                                                                                |                                             |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Baltimore County</b> |                                                                                                                                                                                                  | 4c. County of Death<br><b>Baltimore</b>                                                        |                                                                                                                                         |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 5. Social Security Number<br><b>002 09 1653</b>                                                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                     | 7. Age (In yrs. last birthday)<br><b>83</b> | If Under 1 Year<br>Months Days                                                                                                                                                                                                                                                              | If Under 24 Hrs.<br>Hours Min.                                  | 8. Date of Birth (Month, Day, Year)<br><b>March 2, 1917</b>                                                                                                                                      |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>New Hampshire</b>                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Usual Residence of Decedent                                                                               |                                                                                                                                                                |                                             |                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                           | 10b. County<br><b>Baltimore</b>                                                                                                                                |                                             | 10c. City, Town or Location<br><b>Baltimore County</b>                                                                                                                                                                                                                                      |                                                                 |                                                                                                                                                                                                  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                         |
| 10e. Street and Number<br><b>9467 Seven Courts Drive</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                           |                                                                                                                                                                |                                             | 10f. Zip Code<br><b>21236</b>                                                                                                                                                                                                                                                               |                                                                 | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                      |                                                                                                |                                                                                                                                         |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                               |                                                                 |                                                                                                                                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                                                                                                         |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                                |                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>T.V. Repairman</b>                                                                                                                                                          |                                                                 |                                                                                                                                                                                                  | 16b. Kind of Business/Industry<br><b>Self Employed</b>                                         |                                                                                                                                         |
| 17. Father's Name (First, Middle, Last)<br><b>Stanley Sheska</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                           |                                                                                                                                                                |                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Butkiewicz</b>                                                                                                                                                                                                                |                                                                 |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Frances Ruth Hubard (Niece)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                                |                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>116 Glider Drive Baltimore, Maryland 21220</b>                                                                                                                                          |                                                                 |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                                |                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St Joseph Church Cem.</b>                                                                                                                                                                                      |                                                                 |                                                                                                                                                                                                  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                              |                                                                                                                                         |
| 21. Signature of Funeral Service Licensee<br><b>Robert Sheska Chopacki</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           |                                                                                                                                                                |                                             | 22. Name and Address of Facility<br><b>Lassahn Funeral Home, Inc<br/>7401 Belair Road Baltimore, Maryland 21236</b>                                                                                                                                                                         |                                                                 |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Sepsis</b><br>Due to (or as a consequence of):<br>b. <b>Metastatic Prostate Cancer</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |                                                                                                           |                                                                                                                                                                |                                             |                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                                                | Approximate Interval Between Onset and Death<br><b>1 week</b><br><br><b>10 years</b>                                                    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                           |                                                                                                                                                                |                                             |                                                                                                                                                                                                                                                                                             |                                                                 | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                                                |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                                |                                             |                                                                                                                                                                                                                                                                                             |                                                                 | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                           |                                                                                                                                                                |                                             | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                 |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                           | 28a. Date of Injury (Month, Day Year)                                                                                                                          |                                             | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                             |                                                                 | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |                                                                                                | 28d. Describe how injury occurred                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                         |                                             | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                                 |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                               |                                                                                                           |                                                                                                                                                                |                                             |                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
| 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                           |                                                                                                                                                                |                                             | 29c. License number<br><b>D53462</b>                                                                                                                                                                                                                                                        |                                                                 | 29d. Date signed (Month, Day, Year)<br><b>7/10/00</b>                                                                                                                                            |                                                                                                |                                                                                                                                         |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jude Munnes MD 7845 Oakwood Road Glen Burnie, MD 21061</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                           |                                                                                                                                                                |                                             |                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                           |                                                                                                                                                                |                                             | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                             |                                                                 |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |



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State of Maryland / Department of Health and Mental Hygiene 00 22407

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><u>Eugene Stewart</u>                                                                                                                                                                                                          |                                                                            |                                                                                                                                                   |                                                  | 2. Date of Death<br>Month <u>July</u> Day <u>6</u> Year <u>2000</u>                                                                                                                          |                                                                                                | 3. Time of Death<br><u>11:20 AM</u>                                              |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><u>Union Memorial Hospital</u>                                                                                                                                                                           |                                                                            |                                                                                                                                                   |                                                  | 4b. City, Town, or Location of Death<br><u>Baltimore</u>                                                                                                                                     |                                                                                                | 4c. County of Death<br><u>N/A</u>                                                |                                                                                                                                                                                                                                                                                             |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><u>218-07-2391</u>                                                                                                                                                                                                                            | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><u>90</u> Yrs.                                                                                                  | If Under 1 Year<br>Months <u>0</u> Days <u>0</u> | If Under 24 Hrs.<br>Hours <u>0</u> Min. <u>0</u>                                                                                                                                             | 8. Date of Birth (Month, Day, Year)<br><u>May 10, 1910</u>                                     |                                                                                  | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                          | 10a. State<br><u>Maryland</u>                                                                                                                                                                                                                                              | 10b. County<br><u>N/A</u>                                                  | 10c. City, Town or Location<br><u>Baltimore</u>                                                                                                   |                                                  |                                                                                                                                                                                              | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                  |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br><u>717 Druid Park Lake Drive</u>                                                                                                                                                                                                                 |                                                                            |                                                                                                                                                   | 10f. Zip Code<br><u>21217</u>                    |                                                                                                                                                                                              | 10g. Citizen of What Country?<br><u>USA</u>                                                    |                                                                                  |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                             |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>          |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>0</u> College (1-4 or 5+) <u>0</u>                                                                                                                                       |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Security Officer</u>              |                                                  | 16b. Kind of Business/Industry<br><u>Johns Hopkins</u>                                                                                                                                       |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                | 17. Father's Name (First, Middle, Last)<br><u>unk.</u>                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                   |                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Emma Stewart</u>                                                                                                                     |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 19a. Informant's Name/Relationship (Type, Print) (Sister)<br><u>Mrs. Gertrude Stevenson</u>                                                                                                                                                                                |                                                                            |                                                                                                                                                   |                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>5302 Eastbury Ave. Apt. C Balto. Md. 21206</u>                                           |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Greenmount Crematory</u>                                             |                                                  | 20c. Location - City or Town, State<br><u>Balto. Md.</u>                                                                                                                                     |                                                                                                | 20d. Date<br><u>7/14/2000</u>                                                    |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br><u>Joseph L. Russ</u>                                                                                                                                                                                                         |                                                                            | 22. Name and Address of Facility<br><u>Joseph L. Russ Funeral Home</u><br><u>2222 W. North Ave. Balto. Md. 21216</u>                              |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><u>Aspiration Pneumonia</u>                                   |                                                                            |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  | Approximate Interval Between Onset and Death<br><u>8 days</u>                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Due to (or as a consequence of):                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Due to (or as a consequence of):                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Due to (or as a consequence of):                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
| Medical Certification: To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                         | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u><br><u>HYPERTENSION, CHRONIC VENOUS STASIS</u><br><u>DERMATITIS TO BILATERAL LOWER EXTREMITIES</u>   |                                                                            |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                      |                                                                            |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                          |                                                                            |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |                                                                            | 28a. Date of Injury (Month, Day, Year)                                                                                                            |                                                  | 28b. Time of Injury<br>M                                                                                                                                                                     |                                                                                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                                                                                             |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |                                                                                                                                                                                                                                                                                             |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
| 29b. Signature and title of certifier<br><u>Jennifer Mathew, MD</u>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                   | 29c. License number<br><u>AT2438946</u>          |                                                                                                                                                                                              | 29d. Date signed (Month, Day, Year)<br><u>July 6, 2000</u>                                     |                                                                                  |                                                                                                                                                                                                                                                                                             |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>JENNIFER MATHEW, MD</u> <u>UNION MEMORIAL HOSPITAL, BALTIMORE, MD</u>                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |
| 31. Date filed (Month, Day, Year)<br><u>JUL 14 2000</u>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                            | 32. Registrar's Signature<br><u>[Signature]</u>                            |                                                                                                                                                   |                                                  |                                                                                                                                                                                              |                                                                                                |                                                                                  |                                                                                                                                                                                                                                                                                             |

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22408

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Robert B. Tipton</b>                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      | 2. Date of Death<br>Month Day Year<br><b>July 11, 2000</b>                                                                                                                                    |                                                                                                                                                                                                  | 3. Time of Death<br><b>9:45 a.m.</b>                                    |                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>Gilchrist Center for Hospice</b>                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      | 4b. City, Town, or Location of Death<br><b>Towson</b>                                                                                                                                         |                                                                                                                                                                                                  | 4c. County of Death<br><b>Baltimore</b>                                 |                                                              |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>413-56-5386</b>                                                                                                                                                                                                                                                                                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                 | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.                                                                                                  | If Under 1 Year<br>Months Days       | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                | 8. Date of Birth (Month, Day, Year)<br><b>March 19, 1938</b>                                                                                                                                     |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Tennessee</b> |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |                                                              |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                   | 10b. County<br><b>Baltimore</b>                                                                                                                                                                                                                                                                            | 10c. City, Town or Location<br><b>Middle River</b>                                                                                                |                                      |                                                                                                                                                                                               | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |                                                                         |                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>1811 Wilson Point Road</b>                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   | 10f. Zip Code<br><b>21220</b>        |                                                                                                                                                                                               | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                   |                                                                         |                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Builder-Owner</b>                 |                                      |                                                                                                                                                                                               | 16b. Kind of Business/Industry<br><b>Construction</b>                                                                                                                                            |                                                                         |                                                              |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                             | 17. Father's Name (First, Middle, Last)<br><b>William Tipton</b>                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Myrtle Moore</b>                                                                                                                      |                                                                                                                                                                                                  |                                                                         |                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Hazel Tipton (wife)</b>                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1811 Wilson Point Road, Baltimore, Maryland 21220</b>                                     |                                                                                                                                                                                                  |                                                                         |                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                           |                                                                                                                                                                                                                                                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Holly Hill Mem. Gardens</b>                                          |                                      | Date<br><b>7/14/2000</b>                                                                                                                                                                      |                                                                                                                                                                                                  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>       |                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      | 22. Name and Address of Facility<br><b>Bruzdzinski Funeral Home, P.A.<br/>1407 Old Eastern Avenue, Essex, Maryland 21221</b>                                                                  |                                                                                                                                                                                                  |                                                                         |                                                              |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>renal cell cancer</b><br>Due to (or as a consequence of): |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                                                                                                                  | Approximate Interval Between Onset and Death<br><b>4 years</b>          |                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):                                                                                                                                               |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | c. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | d. Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |                                                              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      |                                                                                                                                                                                               | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                                         |                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      |                                                                                                                                                                                               | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                                         |                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      |                                                                                                                                                                                               | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                                         |                                                              |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                 | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |                                                              |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                 | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                     |                                                                                                                                                   | 28b. Time of Injury<br>M             |                                                                                                                                                                                               | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                 |                                                                         | 28d. Describe how injury occurred                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                 | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                     |                                                                                                                                                   |                                      |                                                                                                                                                                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                                         |                                                              |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |                                                              |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   | 29c. License number<br><b>025205</b> |                                                                                                                                                                                               | 29d. Date signed (Month, Day, Year)<br><b>July 11, 2000</b>                                                                                                                                      |                                                                         |                                                              |
| 30. Name and address of person who completed cause of death (Check 23a) (Type, Print)<br><b>W.A. Riley, 6201 N. Charles St. Balto. Md 21207</b>                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |                                                              |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                 | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                              |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |                                                              |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                      |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |                                                              |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22409

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                             |                                                                                                                                             |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br><u>EDITH TIMANUS</u>                              |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   | 2. Date of Death<br>Month <u>JULY</u> Day <u>14</u> Year <u>2000</u> |                                                                                                                                                                                                          | 3. Time of Death<br><u>9:00 am</u>                          |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br><u>14895 BUSHY PARK RD.</u> |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   | 4b. City, Town, or Location of Death<br><u>WOODBINE</u>              |                                                                                                                                                                                                          | 4c. County of Death<br><u>HOWARD</u>                        |                                                                                                                                             |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br><u>212-20-3258</u>                                               |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                   | 7. Age (In yrs. last birthday)<br><u>74</u> Yrs.                     |                                                                                                                                                                                                          | 8. Date of Birth (Month, Day, Year)<br><u>AUG. 29, 1925</u> |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>                                   |                                                                                                                                                                                                                                                                                                         | 10a. State<br><u>Maryland</u>                                                  |                                                                                                                                                                                                   | 10b. County<br><u>Howard</u>                                         |                                                                                                                                                                                                          | 10c. City, Town or Location<br><u>Woodbine</u>              |                                                                                                                                             |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                               | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                      |                                                                                | 10e. Street and Number<br><u>14895 Bushy Park Rd.</u>                                                                                                                                             |                                                                      | 10f. Zip Code<br><u>21797</u>                                                                                                                                                                            |                                                             | 10g. Citizen of What Country?<br><u>United States</u>                                                                                       |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                             |                                                                                               | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>white</u>                                                                                                                                  |                                                             |                                                                                                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> Collage (1-4 or 5+) <u></u>                                                                                                                                                                                                                                                                                                               |                                                                                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Secretary</u>                                                                                                                                                                           |                                                                                | 16b. Kind of Business/Industry<br><u>Clerical</u>                                                                                                                                                 |                                                                      | 17. Father's Name (First, Middle, Last)<br><u>Frank Islaub</u>                                                                                                                                           |                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Edith Smith</u>                                                                     |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Susan Baxter / daughter</u>                                                                                                                                                                                                                                                                                                                                                                 |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>14895 Bushy Park Rd. Woodbine, MD. 21797</u>                                                  |                                                                      |                                                                                                                                                                                                          |                                                             |                                                                                                                                             |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                    |                                                                                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Crest Lawn</u>                                                                                                                                                                                                             |                                                                                | Date <u>July 17 2000</u>                                                                                                                                                                          |                                                                      | 20c. Location - City or Town, State<br><u>Marriottsville, MD.</u>                                                                                                                                        |                                                             |                                                                                                                                             |  |
| 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               | 22. Name and Address of Facility<br><u>Harry H. Witzke's Family Funeral Home, Inc.</u><br><u>4112 Old Columbia Pike Ellicott City, MD. 21043</u>                                                                                                                                                        |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                             |                                                                                                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                               | a. <u>METASTATIC LUNG CARCINOMA</u><br>Due to (or as a consequence of):<br>b. <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u><br>Due to (or as a consequence of):<br>c. <u>ATHEROSCLEROSIS</u><br>Due to (or as a consequence of):<br>d. <u></u>                                                           |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                             | Approximate Interval Between Onset and Death<br><u>1 yr</u><br><u>YRS</u><br><u>YRS</u>                                                     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                             |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                             |                                                                                                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                              |                                                                                               | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                             |                                                                                                                                             |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                             |                                                                                               | 28a. Date of Injury (Month, Day, Year)<br><u></u>                                                                                                                                                                                                                                                       |                                                                                | 28b. Time of Injury<br><u>M</u>                                                                                                                                                                   |                                                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                                                             | 28d. Describe how injury occurred                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                             | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                   |                                                                                               | 29b. Signature and title of certifier<br><u>[Signature]</u>                                                                                                                                                                                                                                             |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                             | 29c. License number<br><u>D31172</u>                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                               | 29d. Date signed (Month, Day, Year)<br><u>JULY 14, 2000</u>                                                                                                                                                                                                                                             |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                             |                                                                                                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>H.A. OKE MD 3460 ELICOTT CITY RD 103 ELICOTT CITY MD 21043</u>                                                                                                                                                                                                                                                                                          |                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                             |                                                                                                                                             |  |
| 31. Date filed (Month, Day, Year)<br><u>JUL 14 2000</u>                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                               | 32. Registrar's Signature<br><u>[Signature]</u>                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                   |                                                                      |                                                                                                                                                                                                          |                                                             |                                                                                                                                             |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22410

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mae Bradley Truesdale

2. Date of Death

Month Day Year  
7 10 2000

3. Time of Death

8:08 a.m.

4a. Facility Name (If not institution, give street and number)

Future Care Canton Harbor

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-22-0727

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
1-13-1922

9. Birthplace (State or Foreign Country)

Va

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2624 Brendan Avenue

10f. Zip Code

21213

10g. Citizen of What Country?

U S A

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

UNK

College (1-4 or 5+)

UNK

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Private Homes

17. Father's Name (First, Middle, Last)

James H. Hunt

18. Mother's Name (First, Middle, Maiden Surname)

Loverne Rucker

19a. Informant's Name/Relationship (Type, Print)

Dwight Smith - Stepson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2624 Brendan Avenue Baltimore, Md 21213

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery

Date

7-14-00

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

John B. Johnson Jr.

22. Name and Address of Facility

March F/H West

4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pancreatic Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DemerolArterio Sclerotic Vascular Disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D 24276

29d. Date signed (Month, Day, Year)

7-13-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2801 Foster Ave 21218-1000 Simon Scrimm MD

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760, 10

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22411

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nannie Maud Taylor

2. Date of Death

July 12, 2000

3. Time of Death

10:40 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Joseph Richey Hospice

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

230-26-1918

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 1, 1923

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Virginia

10b. County

Spotsylvania

10c. City, Town or Location

Fredericksburg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9733 Glenwood Drive

10f. Zip Code

22408

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Public School Sys.

17. Father's Name (First, Middle, Last)

Moses Carter

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Davis

19a. Informant's Name/Relationship (Type, Print)

Ms. Constance Carter (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3109 Kingsway Rd. Washington, Md. 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Little Mine Rd. Bapt. Ch. Cem.

Date

7/16/2000

20c. Location - City or Town, State

Spotsylvania, Va.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lung cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

year +

b. Liver metastases

Due to (or as a consequence of):

year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Richey hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Thomas M. D.

29c. License number

D13006

29d. Date signed (Month, Day, Year)

7/12/2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Powell, 101 W. Read St. Baltimore 21201

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

Denise P. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

00 22412

AMENDED ITEMS 23a, 27, 28a-f PER ME G785 7/17/00 AH

## Certificate of Death

Reg. No.

|                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br>Robert Douglas Tormollan, Jr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month Day Year<br>JULY 09, 2000                                                                                                                                             |  | 3. Time of Death<br>03:13 A.M.                                                                 |  |
|                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br>JOHNS HOPKINS BAYVIEW MEDICAL CENTER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br>BALTIMORE                                                                                                                                               |  | 4c. County of Death<br>N/A                                                                     |  |
| Funeral<br>Director                                                                                                                                | 5. Social Security Number<br>220-68-2323                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br>29 Yrs.                                                                                                                                                       |  | 8. Date of Birth (Month, Day, Year)<br>Sept. 13, 1970                                          |  |
|                                                                                                                                                    | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10b. County<br>Baltimore                                                                                                                                                                                                                                                                    |  | 10c. City, Town or Location<br>Edgemere                                                                                                                                                         |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Funeral Director                                                                                                                | 10e. Street and Number<br>7703 Bauers Farm Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  | 10f. Zip Code<br>21219                                                                                                                                                                          |  | 10g. Citizen of What Country?<br>United States                                                 |  |
|                                                                                                                                                    | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                          |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |
|                                                                                                                                                    | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9 Years College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Painter                                                                            |  | 16b. Kind of Business/Industry<br>Painters Union                                               |  |
|                                                                                                                                                    | 17. Father's Name (First, Middle, Last)<br>Robert D. Tormollan, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Rebecca Ratliff                                                                                                                            |  |                                                                                                |  |
|                                                                                                                                                    | 19a. Informant's Name/Relationship (Type, Print) (Father)<br>Mr. Robert Tormollan, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2419 Wythe Ave. Edgemere, Maryland 21219                                                       |  |                                                                                                |  |
|                                                                                                                                                    | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sacred Ht. of Jesus Cem.                                                                                                                                                                                          |  | 20c. Location - City or Town, State<br>7/13/2000 Dundalk, Maryland                                                                                                                              |  |                                                                                                |  |
|                                                                                                                                                    | 21. Signature of Funeral Service Licensee<br><i>Stephen Massey</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave. Dundalk, Maryland 21222                                                                           |  |                                                                                                |  |
|                                                                                                                                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. DROWNING AND ETHANOL INTOXICATION<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                |  |
|                                                                                                                                                    | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                |  |
|                                                                                                                                                    | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner                                                                               | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                                |  |
|                                                                                                                                                    | 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                              |  | 28a. Date of Injury (Month, Day, Year)<br>FOUND: 7/9/00                                                                                                                                                                                                                                     |  | 28b. Time of Injury<br>UNKNOWN M                                                                                                                                                                |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |
|                                                                                                                                                    | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) PIER                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28d. Describe how injury occurred SUBJECT DROWNED                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                |  |
|                                                                                                                                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State) BALTO., MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 7713 IROQUOIS RD.                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                 |  |                                                                                                |  |
| State Registrar                                                                                                                                    | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                             |  | 29c. License number<br>O.C.M.E.                                                                                                                                                                 |  | 29d. Date signed (Month, Day, Year)<br>JULY 9, 2000                                            |  |
|                                                                                                                                                    | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                                |  |
|                                                                                                                                                    | 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 32. Registrar's Signature<br><i>B. Sparks</i>                                                                                                                                                   |  |                                                                                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Sandra Gertrude Watkins

2. Date of Death

Month  
JulyDay  
11Year  
2000

3. Time of Death

0600 AM

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

220-54-7234

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

51

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

1-9-1949

9. Birthplace (State or Foreign Country)

Md

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

320 S. Herring Court

10f. Zip Code

21231

10g. Citizen of What Country?

U S A

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Custodian

16b. Kind of Business/Industry

Hotel

17. Father's Name (First, Middle, Last)

Alfred E. Smith

18. Mother's Name (First, Middle, Maiden Surname)

Naomi Watkins

19a. Informant's Name/Relationship (Type, Print)

Andrea Elliott - Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6810 Park Heights Apt 309 Baltimore, Md 21215

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory

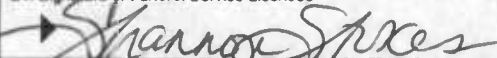
Date

7-17-00

20c. Location - City or Town, State

Catonsville, Md

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

March F/H West

4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

10 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

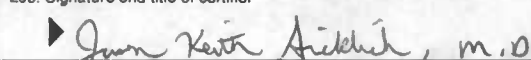
M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

RES-000

29d. Date signed (Month, Day, Year)

July 11, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Jason Keith Sicklick, M.D., Johns Hopkins Hospital, 600 North Wolfe Street, Black 655,

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
2025.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

ORIGINAL





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State of Maryland / Department of Health and Mental Hygiene

amend item 16b per fh G785 7/14/00 yg

## Certificate of Death

Reg. No.

00 22414

|                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                   |                                                            |                                                                                                                                                                                               |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><b>Fred M. Watson</b>                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                              | 2. Date of Death<br>Month <b>July</b> Day <b>8</b> Year <b>2000</b>                                                                               |                                                            | 3. Time of Death<br><b>9:51AM</b>                                                                                                                                                             |
|                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                          |                                                            | 4c. County of Death                                                                                                                                                                           |
| Funeral<br>Director                                                                                                                                                                                                                                                           | 5. Social Security Number<br><b>243-14-3651</b>                                                                                                                                                                                                                                                                                                                                                                                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                   | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.                                                                                                  | If Under 1 Year<br>Months Days                             | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                |
|                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                              | 6. Date of Birth (Month, Day, Year)<br><b>11 14 21</b>                                                                                            |                                                            | 9. Birthplace (State or Foreign Country)<br><b>N.C.</b>                                                                                                                                       |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                           | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                         | 10b. County<br><b>NA</b>                                                                                                                                                                                                                                                                                                                                                                                                     | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                   |                                                            | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                |
|                                                                                                                                                                                                                                                                               | 10e. Street and Number<br><b>2018 Northbourne Road</b>                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                              | 10f. Zip Code<br><b>21239</b>                                                                                                                     |                                                            | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                |
|                                                                                                                                                                                                                                                                               | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|                                                                                                                                                                                                                                                                               | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+) <b>na</b> |                                                            |                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Forklift Operator</b>                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                              | 16b. Kind of Business/Industry<br><b>Brickyard</b><br><del>Perick Yard</del>                                                                      |                                                            |                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br><b>Harris</b>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Watson</b>                                                                           |                                                            |                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                               | 19a. Informant's Name/Relationship (Type, Print)<br><b>Warrington Smith-Son</b>                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2018 Northbourne Road, Baltimore Md 21239</b> |                                                            |                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Cem. 7/13/2000 Dulaney Valley, Md</b>                 |                                                            | 20c. Location - City or Town, State                                                                                                                                                           |
|                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                              | 22. Name and Address of Facility<br><b>March F/H WEST</b><br><b>4300 Wabash Ave, Baltimore Md 21215</b>                                           |                                                            |                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Ventricular Fibrillation</b><br>Due to (or as a consequence of):<br><b>Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br><b>Atherosclerosis</b><br>Due to (or as a consequence of):<br><b>Hypertension</b> |                                                                                                                                                                                                                                                                                                                                                                                                                              | Approximate Interval Between Onset and Death<br><b>30 min</b><br><b>40 min</b><br><b>&gt; 1 year</b><br><b>&gt; 2 years</b>                       |                                                            |                                                                                                                                                                                               |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                             |                                                                                                                                                   |                                                            |                                                                                                                                                                                               |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                      |                                                                                                                                                   |                                                            |                                                                                                                                                                                               |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                  |                                                                                                                                                   |                                                            |                                                                                                                                                                                               |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide |                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                              |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                            |                                                                                                                                                                                               |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                   |                                                            |                                                                                                                                                                                               |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 29c. License number<br><b>D38956</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                   | 29d. Date signed (Month, Day, Year)<br><b>July 8, 2000</b> |                                                                                                                                                                                               |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Edward A. Seidel MD 5601 Loch Raven, Baltimore MD</b>                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                   |                                                            |                                                                                                                                                                                               |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                   |                                                            |                                                                                                                                                                                               |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22415

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                               |                                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>GEORGE NMN WENDLING</b>                                           |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>JULY 9, 2000</b>  |                                                                                                                                                                                               | 3. Time of Death<br><b>7:30 AM</b>         |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>7975 CRAIN HIGHWAY, GLEN FORREST APT. 3</b> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>GLEN BURNIE</b> |                                                                                                                                                                                               | 4c. County of Death<br><b>ANNE ARUNDEL</b> |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>212-12-7367</b>                                                                  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>82 Yrs.</b>           | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 1, 1917</b>                                                                                                                                    |                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>                                                      |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                               |                                            |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                               |                                            |
| 10a. State<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                  | 10b. County<br><b>ANNE ARUNDEL</b>                                                                                                                                                                                                                                                          |                                                            | 10c. City, Town or Location<br><b>GLEN BURNIE</b>                                                                                                                                             |                                            |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                               |                                            |
| 10e. Street and Number<br><b>7975 CRAIN HIGHWAY, GLEN FOREST APT. 3</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                  | 10f. Zip Code<br><b>21061</b>                                                                                                                                                                                                                                                               |                                                            | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                |                                            |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1945-</b><br>If Yes, Give Year or Dates: <b>1946</b>                                                                                                                  |                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                            |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                               |                                            |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b><br>College (1-4 or 5+)                                                                                                                                                                                                                                                                                            |                                                                                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DISTILLER</b>                                                                                                                                                               |                                                            | 16b. Kind of Business/Industry<br><b>MONUMENTAL DISTILLERY</b>                                                                                                                                |                                            |
| 17. Father's Name (First, Middle, Last)<br><b>PETER WENDLING</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>KATHAUINA AGNES</b>                                                                                                                                                                                                                 |                                                            |                                                                                                                                                                                               |                                            |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>MRS. BERNICE WENDLING (WIFE)</b>                                                                                                                                                                                                                                                                                                                                   |                                                                                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7975 CRAIN HIGHWAY, GLEN FOREST APT. 3, GLEN BURNIE, MD. 21061</b>                                                                                                                      |                                                            |                                                                                                                                                                                               |                                            |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                                                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHESAPEAKE CREMATION CENTER, LLC. STEVENSVILLE, MD.</b>                                                                                                                                                        |                                                            | 20c. Location - City or Town, State                                                                                                                                                           |                                            |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                  | 22. Name and Address of Facility<br><b>SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061</b>                                                                                                                                                                      |                                                            |                                                                                                                                                                                               |                                            |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>a. Parkinson's disease</b><br>Due to (or as a consequence of):<br><br><b>b. Lung Cancer</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |                                                                                                                  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |                                                            | 23c. Approximate Interval Between Onset and Death<br><b>2 weeks</b><br><b>2 weeks</b>                                                                                                         |                                            |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                            |                                                                                                                                                                                               |                                            |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                            |                                                                                                                                                                                               |                                            |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |                                                                                                                  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                               |                                            |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                                                  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                            | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                  |                                            |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                  | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                   |                                                            | 29c. License number<br><b>D40519</b>                                                                                                                                                          |                                            |
| 29d. Date signed (Month, Day, Year)<br><b>7/12/00</b>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                               |                                            |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>7845 OAKWOOD Rd GLEN BURNIE MD. 21061</b>                                                                                                                                                                                                                                                                                      |                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                               |                                            |
| 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                  | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                               |                                                            |                                                                                                                                                                                               |                                            |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

00 22416

## Certificate of Death

Reg. No.

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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1. Decedent's Name (First, Middle, Last)<br><b>Camille A. Wright</b>                    |                                                                                                                                                                                                                                                                                                            |                                                                                |                                                                                                                                                                                                                                                                                        | 2. Date of Death<br>Month Day Year<br><b>JULY 12 2000</b> |                                                                                                                                                            |                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 3. Time of Death<br><b>3:55 A</b>               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b> |                                                                                                                                                                                                                                                                                                            |                                                                                |                                                                                                                                                                                                                                                                                        | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |                                                                                                                                                            |                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 4c. County of Death                             |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 5. Social Security Number<br><b>212-33-0899</b>                                         |                                                                                                                                                                                                                                                                                                            | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                        | 7. Age (In yrs. last birthday)<br><b>17</b>               |                                                                                                                                                            | If Under 1 Year<br>Months Days  |                                                                                                                                                                                                                                                                                                                                                                                                                                                     | If Under 24 Hrs.<br>Hours Min.                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 8. Date of Birth (Month, Day, Year)<br><b>12/13/1982</b>                                |                                                                                                                                                                                                                                                                                                            | 9. Birthplace (State or Foreign Country)<br><b>Jamaica</b>                     |                                                                                                                                                                                                                                                                                        | 10a. State<br><b>Maryland</b>                             |                                                                                                                                                            | 10b. County<br><b>Baltimore</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 10c. City, Town or Location<br><b>Baltimore</b> |  |
| 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                         | 10e. Street and Number<br><b>2900 Violet Avenue</b>                                                                                                                                                                                                                                                        |                                                                                | 10f. Zip Code<br><b>21215</b>                                                                                                                                                                                                                                                          |                                                           | 10g. Citizen of What Country?<br><b>Jamaica</b>                                                                                                            |                                 | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                              |                                                 |  |
| 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                         | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                           |                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                |                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b><br>College (1-4 or 5+) <b>Student</b>             |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>                                                                                                                                                                                                                                                                                                                         |                                                 |  |
| 16b. Kind of Business/Industry<br><b>Education</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                         | 17. Father's Name (First, Middle, Last)<br><b>John Wright</b>                                                                                                                                                                                                                                              |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gwendolyn James</b>                                                                                                                                                                                                            |                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gwendolyn Wright / Mother</b>                                                                       |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2900 Violet Ave., Baltimore, Maryland 21215</b>                                                                                                                                                                                                                                                                                                 |                                                 |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>                                                                                                                                                                                                         |                                                                                | 20c. Location - City or Town, State<br><b>07/18/00 Landsdowne, Maryland</b>                                                                                                                                                                                                            |                                                           | 21. Signature of Funeral Service Licensee<br>                                                                                                              |                                 | 22. Name and Address of Facility<br><b>Derrick C. Jones Funeral Home<br/>4611 Park Heights Ave., Baltimore, Maryland 21215</b>                                                                                                                                                                                                                                                                                                                      |                                                 |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Gunshot Wound of Back of Head</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |                                                                                         | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                   |                                                                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                         |                                                           | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No     |                                 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                              |                                                 |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                         | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |                                                           | 28a. Date of Injury (Month, Day, Year)<br><b>Found 7/12/00</b>                                                                                             |                                 | 28b. Time of Injury<br><b>unknown</b>                                                                                                                                                                                                                                                                                                                                                                                                               |                                                 |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                         | 28d. Describe how Injury occurred<br><b>Subject Shot</b>                                                                                                                                                                                                                                                   |                                                                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Street</b>                                                                                                                                                                                |                                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Spring Hill Avenue Baltimore</b>                                        |                                 | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, and manner stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                 |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                         | 29c. License number<br><b>O.C.M.E</b>                                                                                                                                                                                                                                                                      |                                                                                | 29d. Date signed (Month, Day, Year)<br><b>JULY 12, 2000</b>                                                                                                                                                                                                                            |                                                           | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b> |                                 | 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                 |  |
| 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                         | 33. Registrar's Title<br><b>Registrar</b>                                                                                                                                                                                                                                                                  |                                                                                | 34. Registrar's Office<br><b>State Registrar</b>                                                                                                                                                                                                                                       |                                                           | 35. Registrar's Address<br><b>111 Penn Street, Baltimore, Maryland 21201</b>                                                                               |                                 | 36. Registrar's Phone<br><b>410-333-1111</b>                                                                                                                                                                                                                                                                                                                                                                                                        |                                                 |  |

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State of Maryland / Department of Health and Mental Hygiene

00 22417

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                          |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br><u>Walter Warren Sr.</u>                                 |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month <u>July</u> Day <u>12</u> Year <u>2000</u> |                                                                                                                                                                                                  | 3. Time of Death<br><u>4:32 PM</u>                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4a. Facility Name (If not institution, give street and number)<br><u>SINAI HOSPITAL OF BALTIMORE</u> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><u>BALTIMORE</u>             |                                                                                                                                                                                                  | 4c. County of Death                                      |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 5. Social Security Number<br><u>219-16-9859</u>                                                      |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><u>74</u> Yrs.                     |                                                                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br><u>10/04/1925</u> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 9. Birthplace (State or Foreign Country)<br><u>Maryland</u>                                          |                                                                                                                                                                                                                                                                                             | 10a. State<br><u>Maryland</u>                                              |                                                                                                                                                                                              | 10b. County<br><u>Baltimore</u>                                      |                                                                                                                                                                                                  | 10c. City, Town or Location<br><u>Baltimore</u>          |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      | 10e. Street and Number<br><u>2909 Dupont Avenue</u>                                                                                                                                                                                                                                         |                                                                            | 10f. Zip Code<br><u>21215</u>                                                                                                                                                                |                                                                      | 10g. Citizen of What Country?<br><u>U.S.A.</u>                                                                                                                                                   |                                                          |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <u>1945</u>                                                                                                                                          |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>                                                                                                                          |                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>Unknown</u> College (1-4 or 5+) <u>College</u>                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Engineer</u>                                                                                                                                                                |                                                                            | 16b. Kind of Business/Industry<br><u>GSA Fort Meade</u>                                                                                                                                      |                                                                      |                                                                                                                                                                                                  |                                                          |  |
| 17. Father's Name (First, Middle, Last)<br><u>Walter Warren</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Blanche L. Worrell</u>                                                                                                               |                                                                      |                                                                                                                                                                                                  |                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Bernetta Warren / Daughter</u>                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2909 Dupont Ave., Baltimore, Maryland 21215</u>                                          |                                                                      |                                                                                                                                                                                                  |                                                          |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                             |                                                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Baltimore National Ceme.</u>                                                                                                                                                                                   |                                                                            | 20c. Location - City or Town, State<br><u>Baltimore, Maryland</u>                                                                                                                            |                                                                      | 20d. Date<br><u>07/17/00</u>                                                                                                                                                                     |                                                          |  |
| 21. Signature of Funeral Service licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><u>Derrick C. Jones Funeral Home</u><br><u>4611 Park Heights Ave., Baltimore, Maryland 21215</u>                                                         |                                                                      |                                                                                                                                                                                                  |                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><u>a. MULTISYSTEM ORGAN FAILURE WITH SEPSIS</u><br>Due to (or as a consequence of):<br><u>b. SEIZURES</u><br>Due to (or as a consequence of):<br><u>c. RHYTHMOPATHIES</u><br>Due to (or as a consequence of):<br><u>d. SEVERE HYPOTENSION</u> |                                                                                                      | Approximate Interval Between Onset and Death<br><u>2 days</u>                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                          |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>HEPATIC FAILURE, PERIPHERAL VASCULAR DISEASE, ALCOHOL ABUSE</u>                                                                                                                                                                                                                                                                                                                                      |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                          |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                     |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                          |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                      | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                          |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                     |                                                                                                      | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                            | 28b. Time of Injury<br><u>M</u>                                                                                                                                                              |                                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                 |                                                          |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                                      |                                                                                                                                                                                                  |                                                          |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                      |                                                                                                      | 29b. Signature and title of certifier<br>                                                                                                                                                                |                                                                            | 29c. License number<br><u>D0052122</u>                                                                                                                                                       |                                                                      | 29d. Date signed (Month, Day, Year)<br><u>JULY 12, 2000</u>                                                                                                                                      |                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>PETA-GAT JACKSON BOOTH, MD 2401 W. BELVEDERE AVE, BALTIMORE, MD 21215</u>                                                                                                                                                                                                                                                                                                                                                              |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                          |  |
| 31. Date filed (Month, Day, Year)<br><u>JUL 14 2000</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                      | 32. Registrar's Signature<br>                                                                                                                                                                           |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                          |  |

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State of Maryland / Department of Health and Mental Hygiene

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Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               |                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                                                                 |                                                                  |                                                                                                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br>Emily Floride Williams                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                               |                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  | 2. Date of Death<br>Month Day Year<br>July 9 2000                                                                                               |                                                                  | 3. Time of Death<br>4:00 pm                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br>Kris Leigh Assisted Living                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                               |                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  | 4b. City, Town, or Location of Death<br>Davidsonville                                                                                           |                                                                  | 4c. County of Death<br>Anne Arundel                                                                |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br>215-12-2926                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                          |  | 7. Age (In yrs. last birthday)<br>99 Yrs.                                                                                                                                                        |  | 8. Date of Birth (Month, Day, Year)<br>July 27, 1900                                                                                            |                                                                  | 9. Birthplace (State or Foreign Country)<br>Maryland                                               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                               |                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                                                                 |                                                                  |                                                                                                    |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                              | 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                               | 10b. County<br>Anne Arundel                                                                                                                                                                                                                                                                                             |  | 10c. City, Town or Location<br>Davidsonville                                                                                                                                                     |  |                                                                                                                                                 |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 10a. Street and Number<br>3913 Birdsville Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               |                                                                                                                                                                                                                                                                                                                         |  | 10f. Zip Code<br>21035                                                                                                                                                                           |  | 10g. Citizen of What Country?<br>USA                                                                                                            |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                                                                                                                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                               |                                                                                                                                                                                                                                                                                                                         |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                           |  |                                                                                                                                                 | 16b. Kind of Business/Industry<br>Own Home                       |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. Father's Name (First, Middle, Last)<br>William Owings                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                               |                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lecie Simmons                                                                              |                                                                  |                                                                                                    |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                    | 19a. Informant's Name/Relationship (Type, Print)<br>Bruce Williams (Son)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               |                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2120 Hunting Fields Dr., Huntingtown, MD 20639 |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                       |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory                                                                                                                                                                                                                               |  | Date<br>07/12 2000                                                                                                                                                                               |  | 20c. Location - City or Town, State<br>Baltimore, MD                                                                                            |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                               |                                                                                                                                                                                                                                                                                                                         |  | 22. Name and Address of Facility<br>Hardesty Funeral Home, P.A.<br>12 Ridgely Avenue, Annapolis, MD 21401                                                                                        |  |                                                                                                                                                 |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>pneumonia</u><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br>36 days |                               |                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                                                                 |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                |                               |                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                                                                 |                                                                  |                                                                                                    |  |
| State<br>Registrar                                                                                                                                                                                                                                                                                                                                                                                                               | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) assisted living |  |                                                                                                                                                                                                  |  |                                                                                                                                                 |                                                                  |                                                                                                    |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                             |                               | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                  |  | 28b. Time of Injury<br>M                                                                                                                                                                         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                            |                                                                  | 28d. Describe how injury occurred                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                  |  |                                                                                                                                                 |                                                                  |                                                                                                    |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               |                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                                                                 |                                                                  |                                                                                                    |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               |                                                                                                                                                                                                                                                                                                                         |  | 29c. License number<br>048314                                                                                                                                                                    |  | 29d. Date signed (Month, Day, Year)<br>7/11/00                                                                                                  |                                                                  |                                                                                                    |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Paul V. Penell 110 N. 1st Dr., Suite 110 Prince Frederick, MD 20678                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                               |                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                                                                 |                                                                  |                                                                                                    |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 32. Registrar's Signature<br> |                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                  |  |                                                                                                                                                 |                                                                  |                                                                                                    |  |



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State of Maryland / Department of Health and Mental Hygiene

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## Certificate of Death

Reg. No.

|                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |                                                    |                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                                                                          |  |                                                                   |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Edith J. Warner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |                                                    | 2. Date of Death<br>Month Day Year<br>July 9 2000                                                                                                                                                                                                                                                                                   |  |                                                                                      |  | 3. Time of Death<br>9:10 pm                                                                                                                                                                              |  |                                                                   |  |
|                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>2194 Hallmark Court                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |                                                    | 4b. City, Town, or Location of Death<br>Gambrills                                                                                                                                                                                                                                                                                   |  |                                                                                      |  | 4c. County of Death<br>Anne Arundel                                                                                                                                                                      |  |                                                                   |  |
| Funeral<br>Director                                                                                                                           | 5. Social Security Number<br>150-01-7077                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                    | 7. Age (In yrs. last birthday)<br>83 Yrs.                                                                                                                                                                                                                                                                                           |  | If Under 1 Year<br>Months Days                                                       |  | 8. Date of Birth (Month, Day, Year)<br>July 3, 1917                                                                                                                                                      |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania          |  |
|                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |                                                    |                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                                                                          |  |                                                                   |  |
| To Be Completed by Funeral Director                                                                                                           | 10a. State<br>PA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10b. County<br>Monroe                                                                                                                                 |                                                    | 10c. City, Town or Location<br>East Stroudsburg                                                                                                                                                                                                                                                                                     |  |                                                                                      |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |  |                                                                   |  |
|                                                                                                                                               | 10a. Street and Number<br>227 Shirley Futch Plaza                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                       |                                                    | 10f. Zip Code<br>18301                                                                                                                                                                                                                                                                                                              |  |                                                                                      |  | 10g. Citizen of What Country?<br>USA                                                                                                                                                                     |  |                                                                   |  |
|                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                 |  |                                                                                      |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |  |                                                                   |  |
|                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |                                                    | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Lab Technician                                                                                                                                                                                                         |  |                                                                                      |  | 16b. Kind of Business/Industry<br>National Drug Co.                                                                                                                                                      |  |                                                                   |  |
|                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>John Annear                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       |                                                    | 18. Mother's Name (First, Middle, Maiden Surname)<br>Martha Bryant                                                                                                                                                                                                                                                                  |  |                                                                                      |  |                                                                                                                                                                                                          |  |                                                                   |  |
| To Be Completed by Physician/Medical Examiner                                                                                                 | 19a. Informant's Name/Relationship (Type, Print)<br>Joan C. Dempsey (Daughter)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                       |                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2194 Hallmark Court, Gambrills, MD 21054                                                                                                                                                                                           |  |                                                                                      |  |                                                                                                                                                                                                          |  |                                                                   |  |
|                                                                                                                                               | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                          |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory                                                             |                                                    | Date<br>07/10 2000                                                                                                                                                                                                                                                                                                                  |  | 20c. Location - City or Town, State<br>Baltimore, MD                                 |  |                                                                                                                                                                                                          |  |                                                                   |  |
|                                                                                                                                               | 21. Signature of Funeral Service Licensee<br><i>Kimberly S. Bone</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |                                                    | 22. Name and Address of Facility<br>Hardesty Funeral Home, P.A.<br>12 Ridgely Avenue, Annapolis, MD 21401                                                                                                                                                                                                                           |  |                                                                                      |  |                                                                                                                                                                                                          |  |                                                                   |  |
|                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Aspiration pneumonia</u><br>Due to (or as a consequence of):<br>b. <u>Stroke</u><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                       |                                                    |                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                                                                          |  | Approximate Interval Between Onset and Death<br>4 days<br>2 weeks |  |
|                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       |                                                    |                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                                                                          |  |                                                                   |  |
| State<br>Registrar                                                                                                                            | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |                                                    | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>Daughter's Residence</u> |  |                                                                                      |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |                                                                   |  |
|                                                                                                                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                |                                                    | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                                                            |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                                                                                                                                                                        |  |                                                                   |  |
|                                                                                                                                               | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       |                                                    | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                        |  |                                                                                      |  |                                                                                                                                                                                                          |  |                                                                   |  |
|                                                                                                                                               | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                            |  |                                                                                                                                                       |                                                    |                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                                                                          |  |                                                                   |  |
|                                                                                                                                               | 29b. Signature and title of certifier<br><i>Paul S Rhodes</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                       |                                                    | 29c. License number<br>D22028                                                                                                                                                                                                                                                                                                       |  |                                                                                      |  | 29d. Date signed (Month, Day, Year)<br>7-10-00                                                                                                                                                           |  |                                                                   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Paul S Rhodes MD 1667 Crofton Centre Crofton MD 21114 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |                                                    |                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                                                                          |  |                                                                   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       | 32. Registrar's Signature<br><i>James B Sparks</i> |                                                                                                                                                                                                                                                                                                                                     |  |                                                                                      |  |                                                                                                                                                                                                          |  |                                                                   |  |





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State of Maryland / Department of Health and Mental Hygiene

00 22420

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                        |                                                    |                                                                                                                                                                                                                                                                                                                                                                      |                                                      |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br>Carroll John Williams                                 |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                        | 2. Date of Death<br>Month Day Year<br>July 8, 2000 |                                                                                                                                                                                                                                                                                                                                                                      | 3. Time of Death<br>5:21 A.M.                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4a. Facility Name (If not Institution, give street and number)<br>Franklin Square Hospital Center |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                        | 4b. City, Town, or Location of Death<br>Rosedale   |                                                                                                                                                                                                                                                                                                                                                                      | 4c. County of Death<br>Baltimore                     |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 5. Social Security Number<br>214-38-6935                                                          |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                        | 7. Age (In yrs. last birthday)<br>59 Yrs.          |                                                                                                                                                                                                                                                                                                                                                                      | 8. Date of Birth (Month, Day, Year)<br>Jan. 16, 1941 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 9. Birthplace (State or Foreign Country)<br>Maryland                                              |                                                                                                                                                                                                                                                                                                         | 10a. State<br>Maryland                                                         |                                                                                                                                                                                                                                                                                        | 10b. County<br>Baltimore                           |                                                                                                                                                                                                                                                                                                                                                                      | 10c. City, Town or Location<br>Middle River          |  |
| 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                   | 10e. Street and Number<br>810 Thimbleberry Road                                                                                                                                                                                                                                                         |                                                                                | 10f. Zip Code<br>21220                                                                                                                                                                                                                                                                 |                                                    | 10g. Citizen of What Country?<br>United States                                                                                                                                                                                                                                                                                                                       |                                                      |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                       |                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                                                                                                                                                                                     |                                                      |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>Not Known                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Salesman                                                                                                                                                                                   |                                                                                | 16b. Kind of Business/Industry<br>Carpet Sales                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                                                                                                                                                                                      |                                                      |  |
| 17. Father's Name (First, Middle, Last)<br>Charles Williams                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Catherine Emkey                                                                                                                                                                                                                                    |                                                                                | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Faye Williams (Wife)                                                                                                                                                                                                          |                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>810 Thimbleberry Road Middle River, MD 21220                                                                                                                                                                                                                        |                                                      |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Corp.                                                                                                                                                                                                         |                                                                                | 20c. Location - City or Town, State<br>Towson, Maryland                                                                                                                                                                                                                                |                                                    | 20d. Date<br>7/10/2000                                                                                                                                                                                                                                                                                                                                               |                                                      |  |
| 21. Signature of Funeral Service Licensee<br>[Signature]                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                   | 22. Name and Address of Facility<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Ave. Dundalk, Maryland 21222                                                                                                                                                                                   |                                                                                |                                                                                                                                                                                                                                                                                        |                                                    |                                                                                                                                                                                                                                                                                                                                                                      |                                                      |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Acute Myocardial Infarction<br>Due to (or as a consequence of):<br>b. Ventricular Arrhythmia<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                   | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                            |                                                                                |                                                                                                                                                                                                                                                                                        |                                                    |                                                                                                                                                                                                                                                                                                                                                                      |                                                      |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertension                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                |                                                                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                              |                                                    | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                          |                                                      |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |                                                    | 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                      |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                     |                                                                                                   | 29b. Signature and title of certifier<br>[Signature]                                                                                                                                                                                                                                                    |                                                                                | 29c. License number<br>D 28762                                                                                                                                                                                                                                                         |                                                    | 29d. Date signed (Month, Day, Year)<br>July 7, 2000                                                                                                                                                                                                                                                                                                                  |                                                      |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Sunil Ahuja 9000 Franklin Square Drive Baltimore, MD 21237                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                   | 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                        |                                                                                | 32. Registrar's Signature<br>[Signature]                                                                                                                                                                                                                                               |                                                    |                                                                                                                                                                                                                                                                                                                                                                      |                                                      |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 22421

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS WILLIAMS

2. Date of Death

JULY 09 00

3. Time of Death

1610

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-52-3612

6. Sex

M 2 F

7. Age (In yrs. last birthday)

53

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 14, 1947

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

Yes 2 No

10e. Street and Number

3034 Fleetwood Avenue

10f. Zip Code

21214

10g. Citizen of What Country?

United States

11. Marital Status

1 Never Married 2 Married

3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

Yes 2 No

If Yes, Give Year or Dates: Vietnam

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Exterminator

16b. Kind of Business/Industry

Pest Control

17. Father's Name (First, Middle, Last)

Charles T. Williams

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Emkey

19a. Informant's Name/Relationship (Type, Print)

Mrs. Catherine Williams (Mother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3034 Fleetwood Ave. Baltimore, MD 21214

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Hilltop Service Corp. 7/12/2000

Data

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.

7922 Wise Ave. Dundalk, Maryland 21222

23a. Part I. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. LIVER FAILURE

Due to (or as a consequence of):

b. LIVER CIRRHOSIS

Due to (or as a consequence of):

c. ALCOHOLISM

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hepatitis C

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M.O.D.

29c. License number

D40356

29d. Date signed (Month, Day, Year)

JULY 09 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WENGISA NAVARRO, MD - 5601 Loch Raven Boulevard, Baltimore MD - 21239

31. Date filed (Month, Day, Year)

JUL 14 2000

32. Registrar's Signature

Benita A. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22422

|                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
|---------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                           | 1. Decedent's Name (First, Middle, Last)<br>Charles Parmele Wise, Sr.                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                      |  | 2. Date of Death<br>Month Day Year<br>July 9 2000                                                                                                                                                                                                                                                       |  | 3. Time of Death<br>6:20 PM                                                          |  |
|                                                                                                                                             | 4a. Facility Name (If not institution, give street and number)<br>St. Joseph Medical Center                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                      |  | 4b. City, Town, or Location of Death<br>Towson                                                                                                                                                                                                                                                          |  | 4c. County of Death<br>Baltimore                                                     |  |
| Funeral<br>Director                                                                                                                         | 5. Social Security Number<br>220-20-6225                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                       |  | 7. Age (In yrs. last birthday)<br>71 Yrs.                                                                                                                                                                                                                                                               |  | 8. Date of Birth (Month, Day, Year)<br>June 26, 1929                                 |  |
|                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br>Illinois                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10a. State<br>Maryland                                                                                                                                               |  | 10b. County<br>Baltimore                                                                                                                                                                                                                                                                                |  | 10c. City, Town or Location<br>Towson                                                |  |
| To Be Completed by Funeral Director                                                                                                         | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                    |  | 10e. Street and Number<br>600 Stevenson Lane                                                                                                                         |  | 10f. Zip Code<br>21286                                                                                                                                                                                                                                                                                  |  | 10g. Citizen of What Country?<br>United States                                       |  |
|                                                                                                                                             | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Korean War Era |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                        |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|                                                                                                                                             | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+                                                                                                                                                                                                                                                                                                                                                                                 |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Executive                                               |  | 16b. Kind of Business/Industry<br>Retail                                                                                                                                                                                                                                                                |  |                                                                                      |  |
|                                                                                                                                             | 17. Father's Name (First, Middle, Last)<br>Gerald Sillman Wise                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                      |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Louise Berry                                                                                                                                                                                                                                       |  |                                                                                      |  |
|                                                                                                                                             | 19a. Informant's Name/Relationship (Type, Print)<br>Isabella S. Wise (Wife)                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                      |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>600 Stevenson Lane Towson, Maryland 21286                                                                                                                                                              |  |                                                                                      |  |
|                                                                                                                                             | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                       |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Green Mount Crematory                                                                      |  | Date<br>7/12/00                                                                                                                                                                                                                                                                                         |  | 20c. Location - City or Town, State<br>Baltimore, Maryland                           |  |
|                                                                                                                                             | 21. Signature of Funeral Service Licensee<br>Steven T. Zitt                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                      |  | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Funeral Home, Inc.<br>6500 York Road Baltimore, Maryland 21212                                                                                                                                                                                   |  |                                                                                      |  |
|                                                                                                                                             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. EXACERBATION of CHRONIC OBSTRUCTIVE PULMONARY DISEASE (14days)<br>Due to (or as a consequence of):<br>b. SEVERE COPD/EMPHYSEMA<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
|                                                                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
|                                                                                                                                             | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
| To Be Completed by Physician/Medical Examiner                                                                                               | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                      |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                                                                      |  |
|                                                                                                                                             | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                             |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                |  | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                                |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                                                                                                                             | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                               |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |  |                                                                                      |  |
|                                                                                                                                             | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                      |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
|                                                                                                                                             | 29b. Signature and title of certifier<br>Richard O'Malley M.D.                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                      |  | 29c. License number<br>D0047625                                                                                                                                                                                                                                                                         |  | 29d. Date signed (Month, Day, Year)<br>July 11, 2000                                 |  |
| State Registrar                                                                                                                             | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Richard O'Malley, M.D. 7600 Osler Drive, Suite 311 Towson, Maryland 21204                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                         |  |                                                                                      |  |
|                                                                                                                                             | 31. Date filed (Month, Day, Year)<br>JUL 14 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                      |  | 32. Registrar's Signature                                                                                                                                                                                                                                                                               |  |                                                                                      |  |





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22423

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |  |
|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Robert Dulin Walls</b>                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month <b>July</b> Day <b>9</b> Year <b>2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 3. Time of Death<br><b>0739</b>                                                                                                             |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4c. County of Death<br><b>WICOMICO</b>                                                                                                      |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>221 12 6282</b>                                                                                                                                                                                                                                                                                                                                                                              |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 23, 1924</b>                                                                                 |  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>Millford, DE</b>                                                                                                                                                                                                                                                                                                                                                              |  | 10a. State<br><b>DE</b>                                                                                                                                                                                                                                                                     |  | 10b. County<br><b>KENT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10c. City, Town or Location<br><b>Millford</b>                                                                                              |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |  | 10e. Street and Number<br><b>6440 Chateau Dr.</b>                                                                                                                                                                                                                                           |  | 10f. Zip Code<br><b>19963</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                              |  |
|                                               | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII Korea 22 yrs</b>                                                                                                                  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>                                                                                                                                                                                                                                                                                        |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)                                                                                                                                                                                   |  | 16b. Kind of Business/Industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 16c. Kind of Business/Industry                                                                                                              |  |
|                                               | 17. Father's Name (First, Middle, Last)<br><b>William Riley Walls</b>                                                                                                                                                                                                                                                                                                                                                        |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Anna Dulin</b>                                                                                                                                                                                                                      |  | 19a. Informant's Name/Relationship (Type, Print) <b>Wife</b><br><b>Margery Ann Mott</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6440 Chateau Dr, Millford, DE 19963</b> |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Capitol Crematory</b>                                                                                                                                                                                          |  | 20c. Date<br><b>7/10/00</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 20d. Location - City or Town, State<br><b>Dover, DE</b>                                                                                     |  |
|                                               | 21. Signature of Funeral Service Licensee<br><b>Lewis D. McKnight</b>                                                                                                                                                                                                                                                                                                                                                        |  | 22. Name and Address of Facility<br><b>McKnight Funeral Home</b><br><b>50 Commerce Street</b><br><b>HARRINGTON, DE 19952</b>                                                                                                                                                                |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>e. <b>MULTIPLE ORGAN DYSFUNCTION</b><br>Due to (or as a consequence of):<br>b. <b>SEPSIS, MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):<br>c. <b>REDO - CORONARY ARTERY BYPASS</b><br>Due to (or as a consequence of):<br>d. <b>CORONARY ARTERY DISEASE</b> |  | Approximate Interval Between Onset and Death<br><br><b>1 day</b><br><br><b>1 day</b><br><br><b>3 days</b>                                   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                             |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                             |  |
|                                               | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 28a. Date of Injury (Month, Day, Year)                                                                                                      |  |
|                                               | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                 |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                                 |  | 29c. License number<br><b>D0053551</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 29d. Date signed (Month, Day, Year)<br><b>7/9/00</b>                                                                                        |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAMES C. TORD</b> <b>201 PINE BLVD RD, SALISBURY, MD</b>                                                                                                                                                                                                                                                                          |  | 31. Date filed (Month, Day, Year)<br><b>JUL 14 2000</b>                                                                                                                                                                                                                                     |  | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                             |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 00 22424

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) Bernard George Yekstat

2. Date of Death  
Month Day Year July 11 2000

3. Time of Death 9:20 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)  
Citizens Nursing Home

4b. City, Town, or Location of Death Havre de Grace

4c. County of Death Harford

5. Social Security Number 212-05-6976

6. Sex 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday) 86 Yrs.

If Under 1 Year Months Days

If Under 24 Hrs. Hours Min.

8. Date of Birth (Month, Day, Year) Dec. 9, 1913

9. Birthplace (State or Foreign Country) Maryland

Usual Residence of Decedent

10a. State Maryland

10b. County Harford

10c. City, Town or Location Bel Air

10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number 1217 Hickory Brook Court

10f. Zip Code 21014

10g. Citizen of What Country? U. S. A.

11. Marital Status  
1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.  
Specify: White

15. Decedent's Education (Specify only highest grade completed)  
Elementary/Secondary (0-12) 12 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
Manager

16b. Kind of Business/Industry  
Stainless Steel

17. Father's Name (First, Middle, Last) Adolph Yekstat

18. Mother's Name (First, Middle, Maiden Surname) Fronika Young

19a. Informant's Name/Relationship (Type, Print) La Vera Mae Yekstat (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1217 Hickory Brook Ct., Bel Air, Maryland 21014

20a. Method of Disposition  
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Memorial Gardens 2000

20c. Location - City or Town, State Middle River, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Bruzdzinski Funeral Home PA  
1407 Old Eastern Avenue, Essex, Maryland 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. dehydration

Due to (or as a consequence of):

b. Alzheimers

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?  
1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?  
1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?  
1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)  
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death  
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work?  
1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Howlett Jackson, M.D.

DD20993

7-12-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howlett Jackson M.D. 611 S. Union Ave Havre De Grace MD 21078

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUL 14 2000

Denise B Sparks

State  
Registrar

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

00 22425

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                      |                                                                                                                                                |                                                             |                                                                                                                                            |                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                 | 1. Decedent's Name (First, Middle, Last)<br><b>IRVIN R ADDISON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                      | 2. Date of Death<br>Month <b>July</b> Day <b>11</b> Year <b>2000</b>                                                                           |                                                             | 3. Time of Death<br><b>12:30 PM</b>                                                                                                        |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                   | 4e. Facility Name (If not institution, give street and number)<br><b>Baltimore Rehabilitation and Extended Care</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                      | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                       |                                                             | 4c. County of Death<br><b>N/A</b>                                                                                                          |                                                       |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                               | 5. Social Security Number<br><b>212-60-4287</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                      | 6. Sex<br><b>15 M 2 F</b>                                                                                                                      | 7. Age (In yrs. last birthday)<br><b>48</b> Yrs.            | 8. Date of Birth (Month, Day, Year)<br><b>03-30-52</b>                                                                                     | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |
|                                                                                                                                                                                                                                                                                                                                                                                   | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                      |                                                                                                                                                |                                                             |                                                                                                                                            |                                                       |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                               | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                      | 10b. County<br><b>BALTIMORE</b>                                                                                                                |                                                             | 10c. City, Town or Location<br><b>OWINGS MILLS</b>                                                                                         |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                   | 10e. Street and Number<br><b>108 ENCHANTED HILL RD. #202</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      | 10f. Zip Code<br><b>21117</b>                                                                                                                  |                                                             | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                   | 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>                                                                               |                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No Specify:</b> |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 TH GRADE</b> College (1-4 or 5+) <b>2 YRS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>LABORER</b>                    |                                                             | 16b. Kind of Business/Industry<br><b>TRADE SHOWS</b>                                                                                       |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                   | 17. Father's Name (First, Middle, Last)<br><b>IRVIN BLOUNT</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HORTENSE ADDISON</b>                                                                   |                                                             |                                                                                                                                            |                                                       |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>HORTENSE WILLIAMS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1100 BOLTON ST. #1116 BALTO. MD- 21201</b> |                                                             |                                                                                                                                            |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                   | 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST</b>                                               |                                                             | 20c. Location - City or Town, State<br><b>1-17-00 OWINGS MILLS, MD</b>                                                                     |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                   | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                      | 22. Name and Address of Facility<br><b>VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NAT'L PIKE, BALTO. MD- 21229</b>                           |                                                             |                                                                                                                                            |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                   | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acquired immunodeficiency syndrome 5 years</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |                                                                                                                                                      | Approximate Interval Between Onset and Death                                                                                                   |                                                             |                                                                                                                                            |                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                   | Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                      | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b>                                               |                                                             |                                                                                                                                            |                                                       |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b>                                                     |                                                                                                                                                |                                                             |                                                                                                                                            |                                                       |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 26. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |                                                                                                                                                |                                                             |                                                                                                                                            |                                                       |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 28a. Date of Injury (Month, Day, Year)                                                                                                               |                                                                                                                                                | 28b. Time of Injury<br><b>M</b>                             |                                                                                                                                            | 28c. Injury at Work?<br><b>1 Yes 2 No</b>             |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 28d. Describe how injury occurred                                                                                                                    |                                                                                                                                                |                                                             |                                                                                                                                            |                                                       |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                      |                                                                                                                                                |                                                             |                                                                                                                                            |                                                       |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                      |                                                                                                                                                |                                                             |                                                                                                                                            |                                                       |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 29c. License number<br><b>D0032548</b>                                                                                                               |                                                                                                                                                | 29d. Date signed (Month, Day, Year)<br><b>July 11, 2000</b> |                                                                                                                                            |                                                       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Perry L. Colvin</b>                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>10 North Greene Street Baltimore, Maryland</b>                                                                                                    |                                                                                                                                                |                                                             |                                                                                                                                            |                                                       |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 32. Registrar's Signature<br>                                                                                                                        |                                                                                                                                                |                                                             |                                                                                                                                            |                                                       |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



NO. 55152

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22426

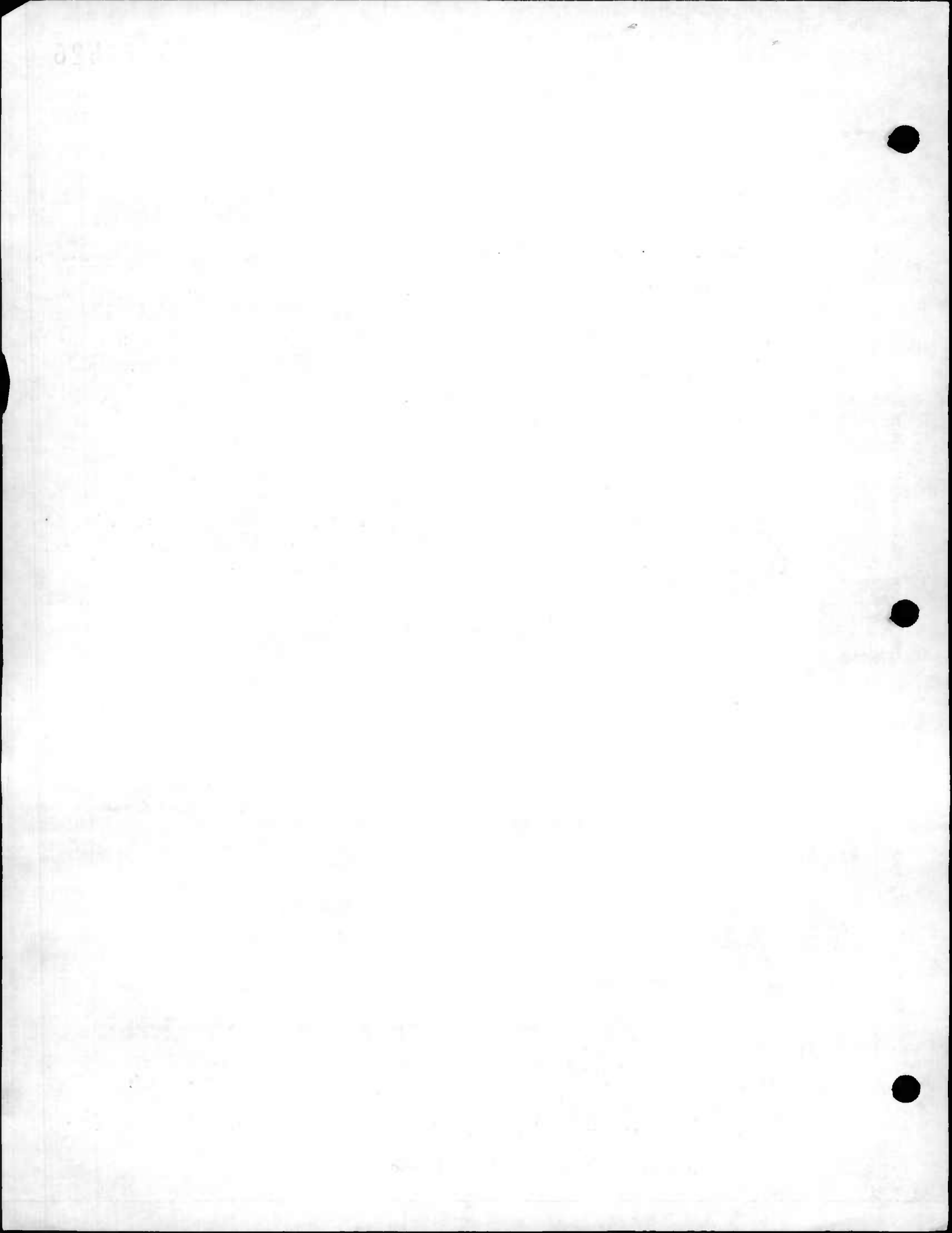
amend item 5 per fh G790 12/6/00 yf

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                                                                                                                   |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                                                                                                                                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>BERNARD FRANCIS ARMSTRONG SR.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                                                                                                                   | 2. Date of Death<br>Month Day Year<br><b>July 13, 2000</b>                                                                                                                                      |                                                                                                | 3. Time of Death<br><b>9:15AM</b>                                       |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not Institution, give street and number)<br><b>1001 Kirkcoln Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                                                                                                                   | 4b. City, Town, or Location of Death<br><b>Towson</b>                                                                                                                                           |                                                                                                | 4c. County of Death<br><b>Baltimore</b>                                 |                                                                                                                                                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>217-20-7673</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>89</b> Yrs.                                                                                                              | If Under 1 Year<br>Months Days                                                                                                                    | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>March 14, 1911</b>                                   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>             |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                                                                                                                   |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                                                                                                                                                  |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                          | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 10b. County<br><b>Baltimore</b>                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>Towson</b>                                                                                                                  |                                                                                                                                                   |                                                                                                                                                                                                 | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                         |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br><b>1001 Kirkcoln Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               | 10f. Zip Code<br><b>21286</b>                                                                                                                     |                                                                                                                                                                                                 | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                                         |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>WWII</b><br>If Yes, Give Year or Dates: |                                                                                                                                                   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4or 5+) <input checked="" type="checkbox"/> <b>5+</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                             | 15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Bank Examiner</b>                             |                                                                                                                                                   |                                                                                                                                                                                                 | 15b. Kind of Business/Industry<br><b>State of Maryland</b>                                     |                                                                         |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 17. Father's Name (First, Middle, Last)<br><b>William Armstrong</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie Maxfield</b>                                                                                                                      |                                                                                                |                                                                         |                                                                                                                                                                                                  |  |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 19a. Informant's Name/Relationship (Type, Print)<br><b>Catherine E. Armstrong DTR</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>94 Dunkirk Road Baltimore, Maryland 21212</b> |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Gar.</b>                                                     |                                                                                                                                                   | Date<br><b>7/17/00</b>                                                                                                                                                                          |                                                                                                | 20c. Location - City or Town, State<br><b>Lutherville, Maryland</b>     |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br><i>Annis Stephen Knack</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               | 22. Name and Address of Facility<br><b>Mitchell-Wiedefeld Funeral Home Inc.<br/>6500 York Road Baltimore, Maryland 21212</b>                      |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br>f. Due to (or as a consequence of):<br><br>g. Due to (or as a consequence of):<br><br>h. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                                                                                                                   |                                                                                                                                                                                                 |                                                                                                |                                                                         | Approximate Interval Between Onset and Death<br><b>5 minute</b>                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                                                                                                                   |                                                                                                                                                                                                 |                                                                                                |                                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                     |                                                                                                                                                               |                                                                                                                                                   |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                                                                                                                                                  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                               |                                                                                                                                                   |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                                                               | 28b. Time of Injury<br><b>M</b>                                                                                                                   |                                                                                                                                                                                                 | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |                                                                         | 28d. Describe how injury occurred                                                                                                                                                                |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 29b. Signature and title of certifier<br><i>Michael T Rudloff</i>                                                                                                                                                                                                                           |                                                                                                                                                               | 29c. License number<br><b>D18095</b>                                                                                                              |                                                                                                                                                                                                 | 29d. Date signed (Month, Day, Year)<br><b>7-14-00</b>                                          |                                                                         |                                                                                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael T Rudloff 1838 Greenview Rd Balte MD 21208</b>                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 31. Date filed (Month, Day, Year)<br><b>JUL 15 2000</b>                                                                                                                                                                                                                                     |                                                                                                                                                               |                                                                                                                                                   |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                                                                                                                                                  |  |
| 32. Registrar's Signature<br><i>Sparks</i>                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                               |                                                                                                                                                   |                                                                                                                                                                                                 |                                                                                                |                                                                         |                                                                                                                                                                                                  |  |

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22427

## Certificate of Death

Reg. No.

AMENDED ITEM #19a PER FH G785 7/17/00 AH

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

George Brown

2. Date of Death

Month Day Year  
7 10 2000

3. Time of Death

5:00 P.M.

4a. Facility Name (If not institution, give street and number)

Gift of Hope

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Maryland

5. Social Security Number

217-40-8345

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Min.

9. Birthplace (State or Foreign Country)

7 7 45

10. Inside City Limits

1 ☒ Yes 2 ☐ No

Usual Residence of Decedent

10a. State

Md

10b. County

N/A

10c. City, Town or Location

Baltimore

10e. Street and Number

818 Collington Ave.

10f. Zip Code

21205

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Furniture Mover

16b. Kind of Business/Industry

J. Norman Geipe

17. Father's Name (First, Middle, Last)

Henry Brown Sr.

18. Mother's Name (First, Middle, Maiden Summa)

Elise Downs

19a. Informant's Name/Relationship (Type, Print)

David Brown - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

902 N. Patterson PK. Ave. Balto, Md. 21205

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Cemetery

Date

7-17-2000

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Miller's Metropolitan Chapel, P.C.  
1639 N. Broadway Balto. Md. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Mycobacterial avium infection

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

b. Retroviral infection

Due to (or as a consequence of):

4 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

Retroviral dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] P. Barditch MD

29c. License number

D35701

29d. Date signed (Month, Day, Year)

7/17/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P. BARDITCH MD

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

[Signature] B Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Informant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Page 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22428

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                  |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                            |                                                                                                                                                                                              |                                                                                                       |                                                                                             |                                                                                                |                                                                 |                                                                |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br><b>Helen Marie Byers</b>                             |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                            | 2. Date of Death<br>Month <b>July</b> Day <b>13</b> Year <b>2000</b>                                                                                                                         |                                                                                                       |                                                                                             |                                                                                                | 3. Time of Death<br><b>2 PM</b>                                 |                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br><b>Union Memorial Hospital</b> |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                            | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                                                                     |                                                                                                       |                                                                                             |                                                                                                | 4c. County of Death<br><b>N/A</b>                               |                                                                |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br><b>189-07-2019</b>                                                  |                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |                                                                                                                                            | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.                                                                                                                                             |                                                                                                       | 8. Date of Birth (Month, Day, Year)<br><b>May 8, 1920</b>                                   |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b> |                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                      |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                            |                                                                                                                                                                                              |                                                                                                       |                                                                                             |                                                                                                |                                                                 |                                                                |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  | 10b. County<br><b>N/A</b> |                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                            |                                                                                                                                                                                              |                                                                                                       |                                                                                             | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                                 |                                                                |  |
| 10e. Street and Number<br><b>3420 Roland Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  |                           |                                                                                                                                                                                                                                                                                             | 10f. Zip Code<br><b>21211</b>                                                                                                              |                                                                                                                                                                                              |                                                                                                       |                                                                                             | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                                 |                                                                |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                  |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                       |                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                                 |                                                                |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (14 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                           |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maker Tags and Tickets</b> |                                                                                                                                                                                              |                                                                                                       |                                                                                             | 16b. Kind of Business/Industry<br><b>Manufacturing Tag and Ticket</b>                          |                                                                 |                                                                |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles H. Byers</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Marie Stambaugh</b>                                                                                                           |                                                                                                       |                                                                                             |                                                                                                |                                                                 |                                                                |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary L. Coffey Sister</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3804 Falls Road Baltimore, Maryland 21211</b>                                            |                                                                                                       |                                                                                             |                                                                                                |                                                                 |                                                                |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial</b>                                                                                                                                                                                       |                                                                                                                                            |                                                                                                                                                                                              | 20c. Location - City or Town, State<br><b>7/17/00 Dorsey, Maryland</b>                                |                                                                                             |                                                                                                |                                                                 |                                                                |  |
| 21. Signature of Funeral Service Licensee<br><b>Burpee B. Heness</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                  |                           | 22. Name and Address of Facility<br><b>Burpee-Henss-Seitz Funeral Home, Inc.<br/>3631 Falls Road, Baltimore, Maryland 21211</b>                                                                                                                                                             |                                                                                                                                            |                                                                                                                                                                                              |                                                                                                       |                                                                                             |                                                                                                |                                                                 |                                                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Aortic Aneurysm</b><br>Due to (or as a consequence of):<br><b>b. Hypertension</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b> |                                                                                                  |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                            |                                                                                                                                                                                              |                                                                                                       |                                                                                             |                                                                                                |                                                                 | Approximate Interval Between Onset and Death<br><b>Minutes</b> |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                  |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                            |                                                                                                                                                                                              | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                             |                                                                                                |                                                                 |                                                                |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                  |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                            |                                                                                                                                                                                              |                                                                                                       |                                                                                             |                                                                                                |                                                                 |                                                                |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  |                           | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                            |                                                                                                                                                                                              |                                                                                                       |                                                                                             |                                                                                                |                                                                 |                                                                |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                  |                           | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                                                                       | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred                               |                                                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                  |                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                                                                                                            |                                                                                                                                                                                              |                                                                                                       |                                                                                             |                                                                                                |                                                                 |                                                                |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                                                                                                        |                                                                                                  |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                            |                                                                                                                                                                                              |                                                                                                       |                                                                                             |                                                                                                |                                                                 |                                                                |  |
| 29b. Signature and title of certifier<br><b>Betsy A. Fay MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                  |                           |                                                                                                                                                                                                                                                                                             | 29c. License number<br><b>033220</b>                                                                                                       |                                                                                                                                                                                              |                                                                                                       |                                                                                             | 29d. Date signed (Month, Day, Year)<br><b>7/14/00</b>                                          |                                                                 |                                                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Betsy A. Fay MD 3830 Falls Rd BALTO MD 21211</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                  |                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                            |                                                                                                                                                                                              |                                                                                                       |                                                                                             |                                                                                                |                                                                 |                                                                |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                  |                           | 32. Registrar's Signature<br><b>Betsy A. Fay</b>                                                                                                                                                                                                                                            |                                                                                                                                            |                                                                                                                                                                                              |                                                                                                       |                                                                                             |                                                                                                |                                                                 |                                                                |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit card.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22429

## Certificate of Death

Reg. No.

AMENDED TIMES #24a, 25 PER MD G785 7/20/00 AH

|                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                         |                                                             |                                                                                        |                                    |                                                                                                                                                                                                  |                                                    |                                                                                                                      |  |                                   |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------|------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br><b>DORIS BEAVER</b>                                       |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month <b>July</b> 1, 2000 Year          |                                                                                        |                                    |                                                                                                                                                                                                  | 3. Time of Death<br><b>3:10 AM</b>                 |                                                                                                                      |  |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br><b>KNOLLWOOD MANOR NURSING HOME</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>Millersville</b> |                                                                                        |                                    |                                                                                                                                                                                                  | 4c. County of Death<br><b>Anne Arundel</b>         |                                                                                                                      |  |                                   |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br><b>219-18-5242</b>                                                       |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.            |                                                                                        | If Under 1 Year<br>Months Days     |                                                                                                                                                                                                  | If Under 24 Hrs.<br>Hours Min.                     |                                                                                                                      |  |                                   |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 8. Date of Birth (Month, Day, Year)<br><b>Sept 10, 1925</b>                                           |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>unk</b>                     |                                                                                                                                                                                                                                                                         | 10a. State<br><b>MD</b>                                     |                                                                                        | 10b. County<br><b>Anne Arundel</b> |                                                                                                                                                                                                  | 10c. City, Town or Location<br><b>Millersville</b> |                                                                                                                      |  |                                   |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                       | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                              |                                                                            | 10e. Street and Number<br><b>899 Cecil Avenue</b>                                                                                                                                                                                                                       |                                                             | 10f. Zip Code<br><b>21108</b>                                                          |                                    | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                      |                                                    |                                                                                                                      |  |                                   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                     |                                                                                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                           |                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                |                                    | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unk</b> College (1-4or 5+) <b>unk</b>                                                          |                                                    | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>unk</b> |  |                                   |  |
| 16b. Kind of Business/Industry<br><b>unk</b>                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                       | 17. Father's Name (First, Middle, Last)<br><b>unk</b>                                                                                                                                                                                                                                       |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unk</b>                                                                                                                                                                                                         |                                                             | 19a. Informant's Name/Relationship (Type, Print)<br><b>Knollwood Manor Nursin Home</b> |                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>899 Cecil Ave Millersville, MD 21108</b>                                                     |                                                    |                                                                                                                      |  |                                   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>in state</b>                                                                                                                                                                                   |                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)                                                                                                                                                                                                                      |                                                                            | Date                                                                                                                                                                                                                                                                    |                                                             | 20c. Location - City or Town, State                                                    |                                    | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>                                                                                                                     |                                                    | 22. Name and Address of Facility<br><b>State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201</b>           |  |                                   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                       | a. <b>Metastatic Carcinoma of Uterus</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                |                                                                            | b. <b>Dementia</b><br>Due to (or as a consequence of):                                                                                                                                                                                                                  |                                                             | c.<br>Due to (or as a consequence of):                                                 |                                    | d.<br>Due to (or as a consequence of):                                                                                                                                                           |                                                    | Approximate Interval Between Onset and Death                                                                         |  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEPRESSION</b>                                                                                                                                                                                                                                                                                                        |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                         |                                                             |                                                                                        |                                    | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                    |                                                                                                                      |  |                                   |  |
| 24e. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                              |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                      |                                                             |                                                                                        |                                    |                                                                                                                                                                                                  |                                                    |                                                                                                                      |  |                                   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                  |                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |                                                             | 28a. Date of Injury (Month, Day, Year)                                                 |                                    | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                    | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                          |  | 28d. Describe how injury occurred |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                          |                                                                                                       | 29b. Signature and title of certifier<br><b>Ronald S. Wade</b>                                                                                                                                                                                                                              |                                                                            | 29c. License number<br><b>D14753</b>                                                                                                                                                                                                                                    |                                                             | 29d. Date signed (Month, Day, Year)<br><b>7/1/00</b>                                   |                                    | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>795 Aqueduct Road, P. Kesville, Maryland 21208</b>                                                    |                                                    |                                                                                                                      |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                       | 32. Registrar's Signature<br><b>Sparks</b>                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                         |                                                             |                                                                                        |                                    |                                                                                                                                                                                                  |                                                    |                                                                                                                      |  |                                   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22430

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY ANN BACKERS

2. Date of Death

Month Day Year  
JULY 12<sup>th</sup> 2000

3. Time of Death

15:05

4a. Facility Name (If not institution, give street and number)

LEVINDALE CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-48-3959

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

97

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
09-01-02

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3503 ELLAMONT ROAD

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6<sup>th</sup> GRADE

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

JOHN MELVIN

18. Mother's Name (First, Middle, Maiden Surname)

RHODA McALLISTER

19a. Informant's Name/Relationship (Type, Print)

ISABELLE WILLIAMS

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3503 ELLAMONT RD., BALTO. MD. 21215

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☒ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ARBUTUS CEMETERY

Date

7-17-00

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Vaughn C. H.

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE  
5151 BALTO. NATL PIKE, BALTO. MD. 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. PNEUMONIA

Due to (or as a consequence of):

5 DAYS

c. DECUBITII

Due to (or as a consequence of):

1 YEAR

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kenna M. Eversley, M.D.

29c. License number

D0054739

29d. Date signed (Month, Day, Year)

JULY 12<sup>th</sup> 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2434 W. BELVERERE AVENUE, BALTIMORE MD 21215

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

Kenna M. Eversley

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

3

State  
Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 22431

Physician  
/Medical  
Examiner

Funeral  
Director

|                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                   |                                                       |                                                                                                                                                                                              |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>Nicoletta G. Bournousouzis</b>                                                                                                                                                                                                                                                                                                                                  |                                                                            | 2. Date of Death<br>Month <b>July</b> Day <b>13</b> Year <b>2000</b>                                                                              |                                                       | 3. Time of Death<br><b>06:35 A.M.</b>                                                                                                                                                        |
| 4a. Facility Name (If not institution, give street and number)<br><b>Prince George's Hospital Center</b>                                                                                                                                                                                                                                                                                                       |                                                                            | 4b. City, Town, or Location of Death<br><b>Cheverly</b>                                                                                           |                                                       | 4c. County of Death<br><b>Prince George's</b>                                                                                                                                                |
| 5. Social Security Number<br><b>218-25-9951</b>                                                                                                                                                                                                                                                                                                                                                                | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>19</b> Yrs.                                                                                                  | If Under 1 Year<br>Months Days<br><b>19</b> <b>19</b> | 8. Date of Birth (Month, Day, Year)<br><b>July 9, 1981</b>                                                                                                                                   |
| 9. Birthplace (State or Foreign Country)<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                   |                                                       |                                                                                                                                                                                              |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                   |                                                       |                                                                                                                                                                                              |
| 10a. State<br><b>MD.</b>                                                                                                                                                                                                                                                                                                                                                                                       | 10b. County<br><b>Harford</b>                                              | 10c. City, Town or Location<br><b>Fallston</b>                                                                                                    |                                                       | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                               |
| 10e. Street and Number<br><b>2402 Rochelle Drive</b>                                                                                                                                                                                                                                                                                                                                                           |                                                                            | 10f. Zip Code<br><b>21047</b>                                                                                                                     |                                                       | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                 |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                       | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                                                                                                                                                        |                                                                            | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>             |                                                       |                                                                                                                                                                                              |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>                                                                                                                                                                                                                                                                                    |                                                                            | 16b. Kind of Business/Industry<br><b>College</b>                                                                                                  |                                                       |                                                                                                                                                                                              |
| 17. Father's Name (First, Middle, Last)<br><b>George Bournousouzis</b>                                                                                                                                                                                                                                                                                                                                         |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Panagiota Androutsopoulos</b>                                                             |                                                       |                                                                                                                                                                                              |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>George Bournousouzis</b>                                                                                                                                                                                                                                                                                                                                |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2402 Rochelle Drive Fallston, MD. 21047</b>   |                                                       |                                                                                                                                                                                              |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                          |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oaklawn Cemetery</b>                                                 |                                                       | 20c. Location - City or Town, State<br><b>7/17/2000 Baltimore, MD.</b>                                                                                                                       |
| 21. Signature of Funeral Service Licensed<br>                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, MD. 21204</b>                                     |                                                       |                                                                                                                                                                                              |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Multiple Injuries</b>                                                                                                                                                                          |                                                                            |                                                                                                                                                   |                                                       |                                                                                                                                                                                              |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                    |                                                                            |                                                                                                                                                   |                                                       |                                                                                                                                                                                              |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                               |                                                                            |                                                                                                                                                   |                                                       |                                                                                                                                                                                              |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                   |                                                       |                                                                                                                                                                                              |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                   |                                                       |                                                                                                                                                                                              |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                              |                                                                            |                                                                                                                                                   |                                                       |                                                                                                                                                                                              |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                    |                                                                            |                                                                                                                                                   |                                                       |                                                                                                                                                                                              |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                     |                                                                            | 28a. Date of Injury (Month, Day, Year)<br><b>7/11/00</b>                                                                                          |                                                       |                                                                                                                                                                                              |
| 28b. Time of Injury<br><b>22:12 M</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                       |                                                       |                                                                                                                                                                                              |
| 28d. Describe how injury occurred<br><b>Driver of Motor Vehicle Collides with Fixed Object</b>                                                                                                                                                                                                                                                                                                                 |                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Street</b>                                           |                                                       |                                                                                                                                                                                              |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Baltimore Washington Parkway; Greenbelt, Md.</b>                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                   |                                                       |                                                                                                                                                                                              |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                            |                                                                                                                                                   |                                                       |                                                                                                                                                                                              |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                      |                                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                            |                                                       | 29d. Date signed (Month, Day, Year)<br><b>July 14, 2000</b>                                                                                                                                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Joseph Pestaner 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                      |                                                                            |                                                                                                                                                   |                                                       |                                                                                                                                                                                              |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                            | 32. Registrar's Signature<br>                                                                                                                     |                                                       |                                                                                                                                                                                              |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 22432

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| 1. Decedent's Name (First, Middle, Last)<br><b>KEVIN A. BOOKER</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                            | 2. Date of Death<br>Month <b>July</b> Day <b>11</b> Year <b>2000</b>                                                                              |                                                                                                                                                 | 3. Time of Death<br><b>11:44 A.M.</b>                                                                                                                                                        |                                                        |
| 4a. Facility Name (If not institution, give street and number)<br><b>Carroll County General Hospital</b>                                                                                                                                                                                                                                                                                                                  |                                                                            |                                                                                                                                                   | 4b. City, Town, or Location of Death<br><b>Westminster</b>                                                                                      |                                                                                                                                                                                              | 4c. County of Death<br><b>Carroll</b>                  |
| 5. Social Security Number<br><b>217-15-3769</b>                                                                                                                                                                                                                                                                                                                                                                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>13</b> Yrs.                                                                                                  | If Under 1 Year<br>Months Days                                                                                                                  | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                               | 8. Date of Birth (Month, Day, Year)<br><b>06-09-87</b> |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 10b. County<br><b>BALTIMORE</b>                                                                                                                   |                                                                                                                                                 | 10c. City, Town or Location<br><b>OWINGS MILLS</b>                                                                                                                                           |                                                        |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 10e. Street and Number<br><b>20 BROOKBURY DRIVE</b>                                                                                                                                                                                                                                                                                                                                                                       |                                                                            | 10f. Zip Code<br><b>21136</b>                                                                                                                     |                                                                                                                                                 | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                  |                                                        |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                        |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                            |                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>8 TH GRADE</b>                                                                                                                                                                                                                                                                                                       |                                                                            | College (1-4 or 5+)<br><b>N/A</b>                                                                                                                 |                                                                                                                                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STUDENT</b>                                                                  |                                                        |
| 16b. Kind of Business/Industry<br><b>SCHOOL</b>                                                                                                                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 17. Father's Name (First, Middle, Last)<br><b>ANTHONY BOOKER</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SHEILA GRAHAM</b>                                                                       |                                                                                                                                                                                              |                                                        |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>SHEILA BOOKER / MOTHER</b>                                                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20 BROOKBURY DR. OWINGS MILLS, MD 21136</b> |                                                                                                                                                                                              |                                                        |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>                                               |                                                                                                                                                 | 20c. Location - City or Town, State<br><b>1-15-00 RANDALLSTOWN, MD</b>                                                                                                                       |                                                        |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>VAUGHN C. GREENE FUNERAL SERVICE<br/>5151 BALTO. NATL PIKE, BALTO. MD. 21229</b>                           |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>DIABETIC KETOACIDOSIS AND LYMPHOCYTIC MYOCARDITIS</b>                                                                                                                                                     |                                                                            |                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                               |                                                                            |                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                            |                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |                                                                            |                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                |                                                                            | 28a. Date of Injury (Month, Day Year)                                                                                                             |                                                                                                                                                 | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                        |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                            | 28d. Describe how injury occurred                                                                                                                 |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                    |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                            |                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                            |                                                                                                                                                 | 29d. Date signed (Month, Day, Year)<br><b>July 12, 2000</b>                                                                                                                                  |                                                        |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                   |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                            | 32. Registrar's Signature<br>                                                                                                                     |                                                                                                                                                 |                                                                                                                                                                                              |                                                        |

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State of Maryland / Department of Health and Mental Hygiene

Amende diTem#23apt11 perPHYG788 10/10/2000 EW

Certificate of Death

Reg. No.

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br><b>Nqomi Boardley</b>                                |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>July 10 2000</b> |                                                                                                                                                                                                                                                                                                                                                                                                                              | 3. Time of Death<br><b>9:45 AM</b>                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b> |                                                                                                                                                   |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |                                                                                                                                                                                                                                                                                                                                                                                                                              | 4c. County of Death<br><b>Baltimore City</b>                |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br><b>220-36-0256</b>                                                  |                                                                                                                                                   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.          |                                                                                                                                                                                                                                                                                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>June 10, 1938</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                      |                                                                                                                                                   | 10a. State<br><b>Maryland</b>                                              |                                                                                                                                                                                              | 10b. County<br><b>N/A</b>                                 |                                                                                                                                                                                                                                                                                                                                                                                                                              | 10c. City, Town or Location<br><b>Baltimore</b>             |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  | 10e. Street and Number<br><b>708 Belgian Ave</b>                                                                                                  |                                                                            | 10f. Zip Code<br><b>21218</b>                                                                                                                                                                |                                                           | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                                                                                                                                                                                                                                               |                                                             |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                                                                                                                                                      |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>                     |                                                                            | 16b. Kind of Business/Industry<br><b>N/A</b>                                                                                                                                                 |                                                           | 17. Father's Name (First, Middle, Last)<br><b>NORMAN Holloway</b>                                                                                                                                                                                                                                                                                                                                                            |                                                             |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EVELYN Campbell</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                  | 19a. Informant's Name/Relationship (Type, Print)<br><b>STEPHEN Boardley</b>                                                                       |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>708 Belgian Ave. Balto, md 21218</b>                                                     |                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                        |                                                             |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST VET. Cem</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                  | 20c. Location - City or Town, State<br><b>Garrison Md</b>                                                                                         |                                                                            | 21. Signature of Funeral Service Licensee<br><b>Blair Adams Jones</b>                                                                                                                        |                                                           | 22. Name and Address of Facility<br><b>W. Jones, JR FHPA<br/>401 Edmondson Ave Balto md 21229</b>                                                                                                                                                                                                                                                                                                                            |                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Pulmonary Embolism</b><br>Due to (or as a consequence of):<br><b>b. Cerebrovascular Accident</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br>Due to (or as a consequence of): |                                                                                                  | Approximate Interval Between Onset and Death<br><b>2 hours</b><br><b>3 weeks</b>                                                                  |                                                                            | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Polio</b> HISTORY OF POLIO IN THE PAST                          |                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                             |                                                             |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No           |                                                                            | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                            |                                                           | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                  |                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                  | 28a. Date of Injury (Month, Day Year)                                                                                                             |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                  |                                                             |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                            |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                                           | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                             |  |
| 29b. Signature and title of certifier<br><b>Attending Physician</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                  | 29c. License number<br><b>D50450</b>                                                                                                              |                                                                            | 29d. Date signed (Month, Day, Year)<br><b>July 10, 2000</b>                                                                                                                                  |                                                           | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Patricia Gregory MD 5601 Loch Raven Blvd POB403 Baltimore MD 21239</b>                                                                                                                                                                                                                                                            |                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 15 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                     |                                                                            | 33. State Registrar                                                                                                                                                                          |                                                           | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020                                                                                                                                                                                                                                                                                                                                                |                                                             |  |

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State of Maryland / Department of Health and Mental Hygiene 00 22434

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                         |                                                                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><u>William Bates</u>                        |                                                                                                                                                   | 2. Date of Death<br>Month <u>July</u> Day <u>08</u> Year <u>2000</u>                                                                                |                                                                                                                                                                                              | 3. Time of Death<br><u>00:44 am</u> |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><u>Mercy Hospital</u> |                                                                                                                                                   | 4b. City, Town, or Location of Death<br><u>Baltimore</u>                                                                                            |                                                                                                                                                                                              | 4c. County of Death<br><u>City</u>  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><u>214-64-4252</u>                                         | 6. Sex<br><u>XX</u> <input type="checkbox"/> M <input type="checkbox"/> F                                                                         | 7. Age (In yrs. last birthday)<br><u>45</u> Yrs.                                                                                                    | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.      |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><u>12-12-54</u>                                  |                                                                                                                                                   | 9. Birthplace (State or Foreign Country)<br><u>MD</u>                                                                                               |                                                                                                                                                                                              |                                     |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                         |                                                                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| 10a. State<br><u>MD</u>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                         | 10b. County<br><u>NA</u>                                                                                                                          |                                                                                                                                                     | 10c. City, Town or Location<br><u>Baltimore</u>                                                                                                                                              |                                     |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |                                                                                         |                                                                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| 10e. Street and Number<br><u>450 N. Robinson Street</u>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                         | 10f. Zip Code<br><u>21224</u>                                                                                                                     |                                                                                                                                                     | 10g. Citizen of What Country?<br><u>USA</u>                                                                                                                                                  |                                     |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                     |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <u>Black</u>                                                                                                                                                                                                                                                                                                                                                   |                                                                                         |                                                                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12th Grade</u><br>College (1-4 or 5+) <u>1yr.</u>                                                                                                                                                                                                                                                                       |                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Chauffeur</u>                     |                                                                                                                                                     | 16b. Kind of Business/Industry<br><u>Baltimore City</u>                                                                                                                                      |                                     |
| 17. Father's Name (First, Middle, Last)<br><u>William Bates</u>                                                                                                                                                                                                                                                                                                                                                           |                                                                                         |                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Nellie Thompson</u>                                                                         |                                                                                                                                                                                              |                                     |
| 19a. Informant's Name/Relationship (Type, Print)<br><u>Dolores Bates</u>                                                                                                                                                                                                                                                                                                                                                  |                                                                                         |                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>450 N. Robinson Street Baltimore, Md. 21224</u> |                                                                                                                                                                                              |                                     |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>King Mem. Pk. Cem. 07-14-2000 Randallstown, MD</u>                   |                                                                                                                                                     | 20c. Location - City or Town, State                                                                                                                                                          |                                     |
| 21. Signature of Funeral Service Licensee<br><u>Gabrielle Cook</u>                                                                                                                                                                                                                                                                                                                                                        |                                                                                         | 22. Name and Address of Facility<br><u>Baltimore, Maryland 21202</u><br><u>WM.C.March FH 1101 E. North Avenue</u>                                 |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                 |                                                                                         |                                                                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| Immediate Cause (Final disease or condition resulting in death)<br><u>Pneumocystis Pneumonia</u>                                                                                                                                                                                                                                                                                                                          |                                                                                         |                                                                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| Due to (or as a consequence of):                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                         |                                                                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |                                                                                         |                                                                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                         |                                                                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                        |                                                                                         |                                                                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                         |                                                                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |                                                                                         |                                                                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                             |                                                                                         | 28a. Date of Injury (Month, Day, Year)                                                                                                            |                                                                                                                                                     | 28b. Time of Injury<br>M                                                                                                                                                                     |                                     |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                                                         | 28d. Describe how injury occurred                                                                                                                 |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                    |                                                                                         | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                      |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                         |                                                                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| 29b. Signature and title of certifier<br><u>Karen A. Kuzich, MD</u>                                                                                                                                                                                                                                                                                                                                                       |                                                                                         | 29c. License number<br><u>D40744</u>                                                                                                              |                                                                                                                                                     | 29d. Date signed (Month, Day, Year)<br><u>July 08, 2000</u>                                                                                                                                  |                                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>K.A. Kuzich, MD Mercy Hospital 301 St Paul Pl. Baltimore, MD 21202</u>                                                                                                                                                                                                                                                         |                                                                                         |                                                                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |
| 31. Date filed (Month, Day, Year)<br><u>JUL 15 2000</u>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                         | 32. Registrar's Signature<br><u>[Signature]</u>                                                                                                   |                                                                                                                                                     |                                                                                                                                                                                              |                                     |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



48135-01

10/1/70

1. The first part of the report deals with the general situation of the country and the progress of the work. It is a very interesting and informative document which gives a clear picture of the current state of affairs. The author has done a very good job of summarizing the various aspects of the situation and has provided a clear and concise account of the progress of the work. The report is well written and is easy to read. It is a very good example of a well written report and is a valuable document for anyone interested in the subject.

2. The second part of the report deals with the specific details of the work. It is a very detailed and thorough account of the various aspects of the work and provides a clear picture of the progress of the work. The author has done a very good job of summarizing the various aspects of the situation and has provided a clear and concise account of the progress of the work. The report is well written and is easy to read. It is a very good example of a well written report and is a valuable document for anyone interested in the subject.

3. The third part of the report deals with the specific details of the work. It is a very detailed and thorough account of the various aspects of the work and provides a clear picture of the progress of the work. The author has done a very good job of summarizing the various aspects of the situation and has provided a clear and concise account of the progress of the work. The report is well written and is easy to read. It is a very good example of a well written report and is a valuable document for anyone interested in the subject.

4. The fourth part of the report deals with the specific details of the work. It is a very detailed and thorough account of the various aspects of the work and provides a clear picture of the progress of the work. The author has done a very good job of summarizing the various aspects of the situation and has provided a clear and concise account of the progress of the work. The report is well written and is easy to read. It is a very good example of a well written report and is a valuable document for anyone interested in the subject.

5. The fifth part of the report deals with the specific details of the work. It is a very detailed and thorough account of the various aspects of the work and provides a clear picture of the progress of the work. The author has done a very good job of summarizing the various aspects of the situation and has provided a clear and concise account of the progress of the work. The report is well written and is easy to read. It is a very good example of a well written report and is a valuable document for anyone interested in the subject.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22435

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                            |                                                                              |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>HATTIE MAE CANNON</b>                                                                                                                                                                                                       |                                                                              | 2. Date of Death<br>Month <b>JULY</b> Day <b>4</b> Year <b>2000</b>                                                                                                                                                                                                                         |                                                             | 3. Time of Death<br><b>12:41</b>                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>                                                                                                                                                                        |                                                                              | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>                                                                                                                                                                                                                               |                                                             | 4c. County of Death<br><b>MD</b>                                                                                                                                                             |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>227-30-9545</b>                                                                                                                                                                                                                            | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.                                                                                                                                                                                                                                            | 8. Date of Birth (Month, Day, Year)<br><b>March 14, '25</b> |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                                                                                                                                                                                                |                                                                              |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | Usual Residence of Decedent                                                                                                                                                                                                                                                |                                                                              | 10a. State<br><b>VA</b>                                                                                                                                                                                                                                                                     |                                                             | 10b. County<br><b>Richmond</b>                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10c. City, Town or Location<br><b>Richmond</b>                                                                                                                                                                                                                             |                                                                              | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                              |                                                             |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>1401 St. James Street, Apt B.</b>                                                                                                                                                                                                             |                                                                              | 10f. Zip Code<br><b>23220</b>                                                                                                                                                                                                                                                               |                                                             | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                             |                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                    |                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>                                                                                                                                      |                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nurse Aide</b>                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 16b. Kind of Business/Industry<br><b>Nursing/ Healthcare</b>                                                                                                                                                                                                               |                                                                              | 17. Father's Name (First, Middle, Last)<br><b>Jesse Jackson</b>                                                                                                                                                                                                                             |                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Moriah Moore</b>                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jean Carey/ Niece</b>                                                                                                                                                                                               |                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1401 St. James Street, Richmond, VA 23220</b>                                                                                                                                           |                                                             |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |                                                                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Oakwood Cemetery</b>                                                                                                                                                                                           |                                                             | 20c. Location - City or Town, State<br><b>Richmond, VA</b>                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br><b>Carlton C. Daughan</b>                                                                                                                                                                                                     |                                                                              | 22. Name and Address of Facility<br><b>Carlton C. Daughan Funeral Service<br/>1701 McCulloch St. Balto. Md. 21217<br/>A.D. Price Funeral Est. 212 E. Leigh St. Rich. VA</b>                                                                                                                 |                                                             |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                  |                                                                              |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | Immediate Cause (Final disease or condition resulting in death)<br><b>a. HYPOXIC ENCEPHALOPATHY</b>                                                                                                                                                                        |                                                                              | Due to (or as a consequence of):                                                                                                                                                                                                                                                            |                                                             | Approximate Interval Between Onset and Death<br><b>2 DAYS</b>                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. STATUS ASTHMATICUS</b>                                                                                 |                                                                              | Due to (or as a consequence of):                                                                                                                                                                                                                                                            |                                                             | <b>2 DAYS</b>                                                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | c.                                                                                                                                                                                                                                                                         |                                                                              | Due to (or as a consequence of):                                                                                                                                                                                                                                                            |                                                             |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | d.                                                                                                                                                                                                                                                                         |                                                                              | Due to (or as a consequence of):                                                                                                                                                                                                                                                            |                                                             |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>                                                                                                     |                                                                              |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                           |                                                                              |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                      |                                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                          |                                                             |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                          |                                                                              | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                             |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |                                                                              | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                             | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                |                                                                              | 28d. Describe how Injury occurred                                                                                                                                                                                                                                                           |                                                             |                                                                                                                                                                                              |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                            |                                                                              |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |
| 29b. Signature and Title of certifier<br><b>Jonathan P. Salazar</b>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                            | 29c. License number<br><b>RES-000</b>                                        |                                                                                                                                                                                                                                                                                             | 29d. Date signed (Month, Day, Year)<br><b>JULY 4 2000</b>   |                                                                                                                                                                                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ANASTASIOS P. SALIARIS, JOHNS HOPKINS HOSPITAL, TOWER 110, BALTIMORE MD 21287</b>                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                            |                                                                              |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                            | 32. Registrar's Signature<br><b>Anne B. Spahr</b>                            |                                                                                                                                                                                                                                                                                             |                                                             |                                                                                                                                                                                              |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22436

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------|-------------------------------------------------------------------|-----------------------------------------|----|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>HELEN A. CRAIG</b>                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br><b>JULY 10, 2000</b>                                                                                                                                    |                                                                                                                                                                                                             | 3. Time of Death<br><b>3:00AM</b>                                       |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>2118 ROCKWELL AVENUE</b>                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                                                                                                                      |                                                                                                                                                                                                             | 4c. County of Death<br><b>BALTIMORE</b>                                 |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>178-07-3798</b>                                                                                                                                                                                                                                                                                                                            | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.                                                                                                  | If Under 1 Year<br>Months Days                                                                                                                          | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                | 8. Date of Birth (Month, Day, Year)<br><b>AUGUST 18, 1914</b>                                                                                                                                               |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>PENNSYLVANIA</b> |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | 10a. State<br><b>MARYLAND</b>                                                                                                                                                                                                                                                                                                                                              | 10b. County<br><b>BALTIMORE</b>                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>BALTIMORE</b>                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                              |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>2118 ROCKWELL AVENUE</b>                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 10f. Zip Code<br><b>21228</b>                                                                                                                           |                                                                                                                                                                                               | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                                                                                                                                                       |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                         | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>BOOKKEEPER</b>                    |                                                                                                                                                         |                                                                                                                                                                                               | 16b. Kind of Business/Industry<br><b>NATIONAL BISCUIT CO.</b>                                                                                                                                               |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. Father's Name (First, Middle, Last)<br><b>GEORGE ANSELL</b>                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MINNIE WORKS</b>                                                                                                                      |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                             | 19a. Informant's Name/Relationship (Type, Print)<br><b>PAUL E. CRAIG / HUSBAND</b>                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2118 ROCKWELL AVENUE, BALTIMORE, MARYLAND 21228</b> |                                                                                                                                                                                               |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                      |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>SCULLTON CEMETERY</b>                                                |                                                                                                                                                         | 20c. Location - City or Town, State<br><b>07-14-00 SOMERSET, PENNSYLVANIA</b>                                                                                                                 |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br><i>Lisa S. Jefferson</i>                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 22. Name and Address of Facility<br><b>LOUDON PARK FUNERAL HOME<br/>3620 WILKENS AVENUE, BALTIMORE, MARYLAND 21229</b>                                  |                                                                                                                                                                                               |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>Acute Respiratory Failure</b></td> <td rowspan="4">Approximate Interval Between Onset and Death<br/><b>&lt;1 hour</b></td> </tr> <tr> <td>b. <b>Invasive Basal Cell Carcinoma</b></td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table> |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                                                                             |                                                                         |                                                                 | Immediate Cause (Final disease or condition resulting in death) | a. <b>Acute Respiratory Failure</b> | Approximate Interval Between Onset and Death<br><b>&lt;1 hour</b> | b. <b>Invasive Basal Cell Carcinoma</b> | c. |
| Immediate Cause (Final disease or condition resulting in death)                                                                                                                                                                                                                                                                                                                                                           | a. <b>Acute Respiratory Failure</b>                                                                                                                                                                                                                                                                                                                                        | Approximate Interval Between Onset and Death<br><b>&lt;1 hour</b>                                                                                                                                                                                                                           |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | b. <b>Invasive Basal Cell Carcinoma</b>                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | c.                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | d.                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                       |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                          |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                            | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>                                                                                                                         |                                                                                                                                                                                               | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                 |                                                                         | 28d. Describe how Injury occurred                               |                                                                 |                                     |                                                                   |                                         |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
| 29b. Signature and title of certifier<br><i>Michael P. Grant MD</i>                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 29c. License number<br><b>RES-000</b>                                                                                                                   |                                                                                                                                                                                               | 29d. Date signed (Month, Day, Year)<br><b>7/14/2000</b>                                                                                                                                                     |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael P. Grant 600 N. Wolfe St Baltimore, MD 21287</b>                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                            | 32. Registrar's Signature<br><i>Benjamin A. Sparks</i>                                                                                                                                                                                                                                      |                                                                                                                                                   |                                                                                                                                                         |                                                                                                                                                                                               |                                                                                                                                                                                                             |                                                                         |                                                                 |                                                                 |                                     |                                                                   |                                         |    |

ORIGINAL



00-3880-510

SYLVIA

COTTMAN

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State of Maryland / Department of Health and Mental Hygiene

00 22437

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                            |                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                            |                                                                                                                                                                                                                                                                            |                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 1. Decedent's Name (First, Middle, Last)<br><b>SYLVIA COTTMAN</b>                          |                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                           | 2. Date of Death<br>Month Day Year<br><b>JULY 13, 2000</b> |                                                                                                                                                                                                                                                                            | 3. Time of Death<br><b>6:33P.M.</b>                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 4a. Facility Name (If not institution, give street and number)<br><b>1633 LORMAN COURT</b> |                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                           | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |                                                                                                                                                                                                                                                                            | 4c. County of Death<br><b>N/A</b>                           |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 5. Social Security Number<br><b>213-32-5922</b>                                            |                                                                                                                                                                                                  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                           | 7. Age (In yrs. last birthday)<br><b>64</b>                |                                                                                                                                                                                                                                                                            | 8. Date of Birth (Month, Day, Year)<br><b>APRIL 14 1936</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                      |                                                                                                                                                                                                  | 10a. State<br><b>MD</b>                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                           | 10b. County<br><b>N/A</b>                                  |                                                                                                                                                                                                                                                                            | 10c. City, Town or Location<br><b>BALTIMORE</b>             |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                            | 10e. Street and Number<br><b>1633 LORMAN COURT</b>                                                                                                                                               |                                                                            | 10f. Zip Code<br><b>21217</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                            | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                |                                                             |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                              |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                                                                                                                                                                                                    |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Collega (1-4 or 5+)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>                                                                    |                                                                            | 16b. Kind of Business/Industry<br><b>Home</b>                                                                                                                                                                                                                                                                                                                                                                             |                                                            | 17. Father's Name (First, Middle, Last)<br><b>CHARLES COTTMAN</b>                                                                                                                                                                                                          |                                                             |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HELEN BOND</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                            | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROSA LEE MAKEL /SISTER</b>                                                                                                                |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1330 LAURENS ST. BALTO., MD. 21217</b>                                                                                                                                                                                                                                                                                |                                                            | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |                                                             |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT ZION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                            | 20c. Location - City or Town, State<br><b>7/18/2000 BALTO., MD.</b>                                                                                                                              |                                                                            | 21. Signature of Funeral Service Licensee<br><b>James A. Morton</b>                                                                                                                                                                                                                                                                                                                                                       |                                                            | 22. Name and Address of Facility<br><b>JAMES A. MORTON &amp; SONS F.H., INC<br/>1701 LAURENS ST. BALTO., MD. 21217</b>                                                                                                                                                     |                                                             |  |
| 23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hypertensive Arteriosclerotic Cardiovascular Disease</b><br>Dua to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Dua to (or as a consequence of):</b><br><b>c. Dua to (or as a consequence of):</b><br><b>d. Dua to (or as a consequence of):</b> |                                                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                                            | 24a. Was an autopsy performed?<br><b>INSPECTION</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                |                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                    |                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                            | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>                                                                                                                  |                                                            | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |                                                             |  |
| 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                  |                                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                          |                                                            | 28d. Describe how injury occurred                                                                                                                                                                                                                                          |                                                             |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                                            | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. |                                                            | 29b. Signature and title of certifier<br><b>J. Pestaner, M.D.</b>                                                                                                                                                                                                          |                                                             |  |
| 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                            | 29d. Date signed (Month, Day, Year)<br><b>JULY 14, 2000</b>                                                                                                                                      |                                                                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JOSEPH PESTANER M.D. 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                            |                                                            | 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                    |                                                             |  |
| 32. Registrar's Signature<br><b>Sparks</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                            |                                                                                                                                                                                                  |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                            |                                                                                                                                                                                                                                                                            |                                                             |  |





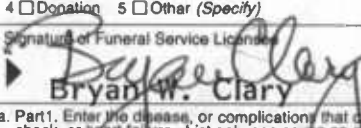
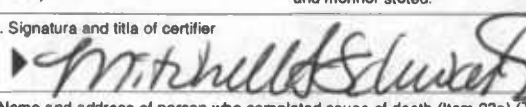

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State of Maryland / Department of Health and Mental Hygiene

00 22438

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                            |                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                  |                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                            |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                          | 1. Decedent's Name (First, Middle, Last)<br><b>Eustace Evans Cramer</b>                                   |                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                  | 2. Date of Death<br>Month Day Year<br><b>JULY 12, 2000</b> |                                                                                                                                                                                                                                                                                                                                                                                                                           | 3. Time of Death<br><b>5:21AM</b>                          |  |
|                                                                                                                                                                                                                                                                            | 4a. Facility Name (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                  | 4b. City, Town, or Location of Death<br><b>TOWSON</b>      |                                                                                                                                                                                                                                                                                                                                                                                                                           | 4c. County of Death<br><b>BALTIMORE</b>                    |  |
| Funeral<br>Director                                                                                                                                                                                                                                                        | 5. Social Security Number<br><b>092-18-7911</b>                                                           |                                                                                                                                                                                                                                                                                                                                                                                                               | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.           |                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><b>March 8 1926</b> |  |
|                                                                                                                                                                                                                                                                            | 9. Birthplace (State or Foreign Country)<br><b>New York</b>                                               |                                                                                                                                                                                                                                                                                                                                                                                                               | 10a. State<br><b>MD</b>                                                    |                                                                                                                                                                  | 10b. County<br><b>Baltimore</b>                            |                                                                                                                                                                                                                                                                                                                                                                                                                           | 10c. City, Town or Location<br><b>Timonium</b>             |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                |                                                                                                           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                |                                                                            | 10e. Street and Number<br><b>11532 Pebble Creek Drive</b>                                                                                                        |                                                            | 10f. Zip Code<br><b>21093</b>                                                                                                                                                                                                                                                                                                                                                                                             |                                                            |  |
| 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                |                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                |                                                                            | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>'41-'46</b> |                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                              |                                                            |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                                                                                    |                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>                                                                                                                                                                                                                                                                          |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Regional Sales Mgr.</b>                          |                                                            | 16b. Kind of Business/Industry<br><b>Black &amp; Decker</b>                                                                                                                                                                                                                                                                                                                                                               |                                                            |  |
| 17. Father's Name (First, Middle, Last)<br><b>Morris Eugene Cramer</b>                                                                                                                                                                                                     |                                                                                                           | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Ella Bergstrom</b>                                                                                                                                                                                                                                                                                                                                      |                                                                            | 19a. Informant's Name/Relationship (Type, Print)<br><b>B. Kelly Cramer/Son</b>                                                                                   |                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>202P Tall Oaks Dr., Weymouth, MASS 02190</b>                                                                                                                                                                                                                                                                          |                                                            |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |                                                                                                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial Gardens</b>                                                                                                                                                                                                                                                                                              |                                                                            | 20c. Location - City or Town, State<br><b>Timonium, MD</b>                                                                                                       |                                                            | 21. Signature of Funeral Service Licensee<br><br><b>Bryan W. Clary</b>                                                                                                                                                                                                                                                                  |                                                            |  |
| 22. Name and Address of Facility<br><b>Lemmon Funeral Home<br/>10 W. Padonia Rd., Timonium, MD 21093</b>                                                                                                                                                                   |                                                                                                           | 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br><b>Advanced Pulmonary Fibrosis</b><br>Due to (or as a consequence of): |                                                                            | Approximate Interval Between Onset and Death                                                                                                                     |                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |                                                            |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                      |                                                                                                           | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                            |                                                                            | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                |                                                            | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |                                                            |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |                                                                                                           | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                  |                                                            | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                            |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                          |                                                                                                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                        |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                     |                                                            | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                            |  |
| 29b. Signature and title of certifier<br><br><b>Mitchell L. Schwartz</b>                                                                                                                |                                                                                                           | 29c. License number<br><b>D-44728</b>                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | 29d. Date signed (Month, Day, Year)<br><b>7/13/00</b>                                                                                                            |                                                            | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mitchell L. Schwartz, M.D. 6569 N. Charles St. Suite 601, Towson, MD 21204</b>                                                                                                                                                                                                                                                 |                                                            |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                    |                                                                                                           | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                              |                                                                            | State Registrar                                                                                                                                                  |                                                            | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.                                                                         |                                                            |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22439

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|-----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Dorothea Hempel Chew                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                 |  | 2. Date of Death<br>Month: July, Day: 14, Year: 2000                                                                                                                                             |  | 3. Time of Death<br>6:04 A.M.                                                                                                                                                                            |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>Gilchrist Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                 |  | 4b. City, Town, or Location of Death<br>Towson                                                                                                                                                   |  | 4c. County of Death<br>Baltimore Co.                                                                                                                                                                     |  |
| Funeral<br>Director                           | 5. Social Security Number<br>215-24-3794                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br>87 Yrs.                                                                                                                                                        |  | 8. Date of Birth (Month, Day, Year)<br>September 27, 1912                                                                                                                                                |  |
|                                               | 9. Birthplace (State or Foreign Country)<br>Baltimore, Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                          |  | 10b. County<br>Worcester Co.                                                                                                                                                                     |  | 10c. City, Town or Location<br>Ocean City                                                                                                                                                                |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | 10e. Street and Number<br>709 Boardwalk & Surf Ave.                                                                                                                                                                                                                                                             |  | 10f. Zip Code<br>21842                                                                                                                                                                           |  | 10g. Citizen of What Country?<br>United States of America                                                                                                                                                |  |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                        |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 12 College (14 or 5+): 02                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Book Keeper                                                                                                                                                                                        |  | 16b. Kind of Business/Industry<br>Building Construction                                                                                                                                          |  |                                                                                                                                                                                                          |  |
|                                               | 17. Father's Name (First, Middle, Last)<br>Christopher Hempel                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                 |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Nellie Werner                                                                                                                               |  |                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Judy C. Boone (Daughter)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                                                                                                                                 |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>16 Kirsim Court Freeland, Maryland 21053                                                        |  |                                                                                                                                                                                                          |  |
|                                               | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):                                                                                                                                                                                                                                                                                                                                              |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hilltop Service Corporation                                                                                                                                                                                                           |  | 20c. Location - City or Town, State<br>Towson, Maryland                                                                                                                                          |  | 20d. Date<br>7/17/2000                                                                                                                                                                                   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Jeffrey L. Gair                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                 |  | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204                                                                                            |  |                                                                                                                                                                                                          |  |
|                                               | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. right hemispheric stroke<br>Due to (or as a consequence of):<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |                                                                                                                                                                                                                                                                                                                 |  | Approximate Interval Between Onset and Death<br>8 months                                                                                                                                         |  |                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|                                               | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                          |  |
|                                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                        |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                          |  | 28b. Time of Injury<br>M                                                                                                                                                                         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                          |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |  |                                                                                                                                                                                                          |  |
|                                               | 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>W.A. Riley, MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                 |  | 29c. License number<br>D25205                                                                                                                                                                    |  | 29d. Date signed (Month, Day, Year)<br>July 14, 2000                                                                                                                                                     |  |
|                                               | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>W.A. Riley, MD, 6701 N. Charles St. Balto. Md 21204                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                  |  |                                                                                                                                                                                                          |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>JUL 17 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                 |  | 32. Registrar's Signature<br>[Signature]                                                                                                                                                         |  |                                                                                                                                                                                                          |  |

ORIGINAL



ANDRE CHAPLE

State of Maryland / Department of Health and Mental Hygiene

00 22440

AMEND ITEMS: #23 PART I, 27 PER MEO G787 8-8-00 WJP

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Andre Chaple, Sr.</b>                                 |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <b>JULY</b> Day <b>8</b> Year <b>2000</b> |                                                                                                                                                                                              | 3. Time of Death<br><b>1039 AM</b> |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL E.R.</b> |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>BAITMORE</b>             |                                                                                                                                                                                              | 4c. County of Death<br><b>NA</b>   |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>213-70-1120</b>                                                      | 6. Sex<br><b>XX</b> <input type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                   | 7. Age (In yrs. last birthday)<br><b>41</b> Yrs.                    | If Under 1 Year<br>Months Days                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><b>03-28-59</b>                                               |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>MD</b>               |                                                                                                                                                                                              |                                    |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                    |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      | 10b. County<br><b>NA</b>                                                                                                                                                                                                                                                                    |                                                                     | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                              |                                    |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                    |
| 10e. Street and Number<br><b>2400 Madison Street</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                      | 10f. Zip Code<br><b>21205</b>                                                                                                                                                                                                                                                               |                                                                     | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                  |                                    |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                            |                                                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                    |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                    |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th Grade</b><br>College (1-4 or 5+) <b>NA</b>                                                                                                                                                                                                                                                                         |                                                                                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Part Time</b>                                                                                                                                                               |                                                                     | 16b. Kind of Business/Industry<br><b>Community Worker Baltimore City</b>                                                                                                                     |                                    |
| 17. Father's Name (First, Middle, Last)<br><b>Frederick D. Chapple</b>                                                                                                                                                                                                                                                                                                                                                    |                                                                                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Annie M. Venable</b>                                                                                                                                                                                                                |                                                                     |                                                                                                                                                                                              |                                    |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Katrina Chapple</b>                                                                                                                                                                                                                                                                                                                                                |                                                                                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21205 2400 E. Madison Street Baltimore, Maryland</b>                                                                                                                                       |                                                                     |                                                                                                                                                                                              |                                    |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                     |                                                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Vesball Mem Gardens</b>                                                                                                                                                                                        |                                                                     | 20c. Location - City or Town, State<br><b>MD Dundalk, MD.</b>                                                                                                                                |                                    |
| 21. Signature of Funeral Service Licensee<br><b>Gabrielle Cook</b>                                                                                                                                                                                                                                                                                                                                                        |                                                                                                      | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>                                                                                                                                                                                     |                                                                     |                                                                                                                                                                                              |                                    |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CARDIAC ARRHYTHMIA</b>                                                                                                                                                                                    |                                                                                                      | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                |                                                                     |                                                                                                                                                                                              |                                    |
| Immediate Cause (Final disease or condition resulting in death)<br><b>CARDIAC ARRHYTHMIA</b>                                                                                                                                                                                                                                                                                                                              |                                                                                                      | Due to (or as a consequence of): <b>FOCAL MYOCARDIAL FIBROSIS &amp; ABNORMALITY "TUNNEL" OF THE ANTERIOR LEFT CORONARY ARTERY</b>                                                                                                                                                           |                                                                     |                                                                                                                                                                                              |                                    |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                                                                                                |                                                                                                      | Due to (or as a consequence of):                                                                                                                                                                                                                                                            |                                                                     |                                                                                                                                                                                              |                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                      | Due to (or as a consequence of):                                                                                                                                                                                                                                                            |                                                                     |                                                                                                                                                                                              |                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                      | Due to (or as a consequence of):                                                                                                                                                                                                                                                            |                                                                     |                                                                                                                                                                                              |                                    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                                                      | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                            |                                                                     |                                                                                                                                                                                              |                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                      | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                       |                                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                      |                                    |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                      | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                     |                                                                                                                                                                                              |                                    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                |                                                                                                      | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                       |                                                                     | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                            |                                                                     | 28d. Describe how Injury occurred                                                                                                                                                            |                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                                    |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                      | 29b. Signature and title of certifier<br><b>Monte Delkull</b>                                                                                                                                                                                                                               |                                                                     | 29c. License number<br><b>O.C.M.E</b>                                                                                                                                                        |                                    |
|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                      | 29d. Date signed (Month, Day, Year)<br><b>JULY 9, 2000</b>                                                                                                                                                                                                                                  |                                                                     |                                                                                                                                                                                              |                                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Mary Ann P. Korol 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                               |                                                                                                      |                                                                                                                                                                                                                                                                                             |                                                                     |                                                                                                                                                                                              |                                    |
| 31. Date filed (Month, Day, Year)<br><b>JUL 15 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                      | 32. Registrar's Signature<br><b>Sparks</b>                                                                                                                                                                                                                                                  |                                                                     |                                                                                                                                                                                              |                                    |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22441

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Walter A. De Deo

2. Date of Death  
Month Day Year  
July 12, 20003. Time of Death  
6:30PMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

3608 Sweet Air Road

4b. City, Town, or Location of Death

Phoenix

4c. County of Death

Baltimore

5. Social Security Number

220-18-6936

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year  
Months DaysIf Under 24 Hrs.  
Hours Min.8. Date of Birth  
(Month, Day, Year)

Dec. 6, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
MD10b. County  
Baltimore10c. City, Town or Location  
Phoenix10d. Inside City Limits  
1 ☐ Yes 2 ☒ No

10e. Street and Number

3608 Sweet Air Road

10f. Zip Code

21131

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 45'-47'13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
N/A18a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Roofing Contractor

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Amilcare De Deo

18. Mother's Name (First, Middle, Maiden Summa)

Adele Pennese

19a. Informant's Name/Relationship (Type, Print)

Mae E. De Deo/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3608 Sweet Air Road Phoenix, MD 21131

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)  
Baltimore Washington  
CrematoryDate  
July 14  
200020c. Location - City or Town, State  
Laurel, MD

21. Signature of Funeral Service Provider

Michael U. Flagle

22. Name and Address of Facility

Lemmon Funeral home of Dulaney Valley, Inc.  
10 W. Padonia Road Timonium, MD 2109323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. A S C V D

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

10 Yrs.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

Edward P. Costlow M.D.

29c. License number

D19503

29d. Date signed (Month, Day, Year)

July 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward P. Costlow, M.D. 10 Gerard Ave. Timonium, MD 21093

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

Benjamin Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22442

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                      |                                                    |                                                                                      |                                                     |                                                                                                                                                                                                          |                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br>EMMA S. DAVIS                                   |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                      | 2. Date of Death<br>Month Day Year<br>JULY 10 2000 |                                                                                      |                                                     |                                                                                                                                                                                                          | 3. Time of Death<br>0801                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br>Fallston General Hospital |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                      | 4b. City, Town, or Location of Death<br>Fallston   |                                                                                      |                                                     |                                                                                                                                                                                                          | 4c. County of Death<br>Harford                 |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br>233-56-0040                                                    |                                                                                                                                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                      | 7. Age (In yrs. last birthday)<br>62 Yrs.          |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>Apr 18, 1938 |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br>WV |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                 |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                      |                                                    |                                                                                      |                                                     |                                                                                                                                                                                                          |                                                |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             | 10b. County<br>Harford                                                                                                                                |                                                                                | 10c. City, Town or Location<br>Street                                                                                                                                                                                                                                                                |                                                    |                                                                                      |                                                     | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |                                                |  |
| 10e. Street and Number<br>201 Davis Road                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                                                                                                                                                       |                                                                                | 10f. Zip Code<br>21154                                                                                                                                                                                                                                                                               |                                                    |                                                                                      |                                                     | 10g. Citizen of What Country?<br>USA                                                                                                                                                                     |                                                |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                           |                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                     |                                                    |                                                                                      |                                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                                                                                                                         |                                                |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4                                                                                                                                                                                                                                                                                                                                                                          |                                                                                             |                                                                                                                                                       |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>secretary                                                                                                                                                                               |                                                    |                                                                                      |                                                     | 16b. Kind of Business/Industry<br>unk                                                                                                                                                                    |                                                |  |
| 17. Father's Name (First, Middle, Last)<br>McHenry A. Snyder                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                             |                                                                                                                                                       |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Dorothy M. Scott                                                                                                                                                                                                                                |                                                    |                                                                                      |                                                     |                                                                                                                                                                                                          |                                                |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Fallston General Hospital                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                             |                                                                                                                                                       |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>200 Milton Avenue Fallston, MD 21047                                                                                                                                                                |                                                    |                                                                                      |                                                     |                                                                                                                                                                                                          |                                                |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                  |                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dele                                                                        |                                                                                | 20c. Location - City or Town, State                                                                                                                                                                                                                                                                  |                                                    |                                                                                      |                                                     |                                                                                                                                                                                                          |                                                |  |
| 21. Signature of Funeral Service Licensee<br>Ronald S. Wade, Director                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                             |                                                                                                                                                       |                                                                                | 22. Name and Address of Facility<br>State Anatomy Board 655 W. Baltimore Street<br>Baltimore, MD 21201                                                                                                                                                                                               |                                                    |                                                                                      |                                                     |                                                                                                                                                                                                          |                                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Ventricular Arrhythmia<br>Due to (or as a consequence of):<br>b. TYPE 2 DIABETES Mellitis<br>Due to (or as a consequence of):<br>c. Hyperlipidemia<br>Due to (or as a consequence of):<br>d. Hypertension |                                                                                             |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                      |                                                    |                                                                                      |                                                     | Approximate Interval Between Onset and Death<br>1 Hour<br>30 YEARS<br>30 YEARS<br>30 YEARS                                                                                                               |                                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                           |                                                                                             |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                      |                                                    |                                                                                      |                                                     | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                      |                                                    |                                                                                      |                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                                |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                            |                                                                                             |                                                                                                                                                       |                                                                                | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                    |                                                                                      |                                                     |                                                                                                                                                                                                          |                                                |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                        |                                                                                             | 28a. Date of Injury (Month, Day, Year)                                                                                                                |                                                                                | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                             |                                                    | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                     | 28d. Describe how injury occurred                                                                                                                                                                        |                                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                             |                                                                                                                                                       |                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                         |                                                    |                                                                                      |                                                     |                                                                                                                                                                                                          |                                                |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                    |                                                                                             |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                      |                                                    |                                                                                      |                                                     |                                                                                                                                                                                                          |                                                |  |
| 29b. Signature and title of certifier<br>Sherif Osman                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                             |                                                                                                                                                       |                                                                                | 29c. License number<br>D 36715                                                                                                                                                                                                                                                                       |                                                    | 29d. Date signed (Month, Day, Year)<br>July 11, 2000                                 |                                                     |                                                                                                                                                                                                          |                                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Sherif Osman, M.D. 39 Churchville Road Bel Air, Maryland 21014                                                                                                                                                                                                                                                                                                                                           |                                                                                             |                                                                                                                                                       |                                                                                |                                                                                                                                                                                                                                                                                                      |                                                    |                                                                                      |                                                     |                                                                                                                                                                                                          |                                                |  |
| 31. Date filed (Month, Day, Year)<br>JUL 17 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                             |                                                                                                                                                       |                                                                                | 32. Registrar's Signature<br>B. Sparks                                                                                                                                                                                                                                                               |                                                    |                                                                                      |                                                     |                                                                                                                                                                                                          |                                                |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22443

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Napoleon Dortch

2. Date of Death

Month Day Year  
JULY 5 2000

3. Time of Death

10:55 PM

4a. Facility Name (If not institution, give street and number)

STELLA MARIS Villa

4b. City, Town, or Location of Death

TIMONIUM

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

254-14-9655

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
7-15-16

9. Birthplace (State or Foreign Country)

Ga.

Usual Residence of Decedent

10a. State  
Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

304 N. ARLINGTON Ave

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 12/10/42  
3/21/46

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MANAGER

16b. Kind of Business/Industry

Jumbo Carryout

17. Father's Name (First, Middle, Last)

John Lev Dortch

18. Mother's Name (First, Middle, Maiden Surname)

Roxanna Reeder

19a. Informant's Name/Relationship (Type, Print)

MARILYN CHARLENE Womble

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1016 N. Central Ave. Balto. Md. 21202

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD Veteran Cemetery

Date

7/13/00

20c. Location - City or Town, State

Balto. Co. MD.

21. Signature of Funeral Service Licensee

J. Miller

22. Name and Address of Facility

Miller's Metropolitan Chapel AC Balto. Md. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Tariq Mahmood

29c. License number

D43725

29d. Date signed (Month, Day, Year)

7/14/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

31. Date filed (Month, Day, Year)

JUL 15 2000

32. Registrar's Signature

Sparks

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at 0024.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

JULY 7, 2000 10:55 p.m.

NAPOLÉON DORTCH





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22444

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                 |                                                                                                                        |                                                                                                                                                      |                                                             |                                                                                                                                                                                              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>DOMINIQUE DERICO</b>                                                                                                                                                                                             |                                                                                                                        | 2. Date of Death<br>Month Day Year<br><b>July 11 2000</b>                                                                                            |                                                             | 3. Time of Death<br><b>18:23</b>                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Hospital</b>                                                                                                                                                                 |                                                                                                                        | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>                                                                                        |                                                             | 4c. County of Death<br><b>NA</b>                                                                                                                                                             |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>199-70-1195</b>                                                                                                                                                                                                                 | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                             | 7. Age (In yrs. last birthday)<br><b>10</b>                                                                                                          | 8. Date of Birth (Month, Day, Year)<br><b>09-24-89</b>      | 9. Birthplace (State or Foreign Country)<br><b>PA</b>                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                     |                                                                                                                        |                                                                                                                                                      |                                                             |                                                                                                                                                                                              |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                         | 10b. County<br><b>NA</b>                                                                                               | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                      |                                                             | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10a. Street and Number<br><b>129 N. Amity Street</b>                                                                                                                                                                                                            |                                                                                                                        | 10f. Zip Code<br><b>21223</b>                                                                                                                        |                                                             | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                  |                                                                                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:    |                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Blac</b>                                                                                                                                                                                          |                                                                                                                        | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4th Grade</b> College (1-4 or 5+) <b>NA</b>        |                                                             |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>                                                                                                                                     |                                                                                                                        | 16b. Kind of Business/Industry<br><b>Elementary School</b>                                                                                           |                                                             |                                                                                                                                                                                              |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                             | 17. Father's Name (First, Middle, Last)<br><b>Travis B. Derico</b>                                                                                                                                                                                              |                                                                                                                        | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LaTasha McCray</b>                                                                           |                                                             |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>LaTasha McCray</b>                                                                                                                                                                                       |                                                                                                                        | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4741 Elison Avenue Baltimore, Maryland 21206</b> |                                                             |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                           |                                                                                                                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Edgewood Cemetery</b>                                                   |                                                             | 20c. Location - City or Town, State<br><b>Orlando, FL.</b>                                                                                                                                   |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br><i>Joseph R. Walter, Jr.</i>                                                                                                                                                                                       |                                                                                                                        | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202</b><br><b>WM.C.March FH 1101 E. North Avenue</b>                                    |                                                             |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Smoke inhalation &amp; thermal burn / complications</b> |                                                                                                                        | Approximate Interval Between Onset and Death<br><b>30 days</b>                                                                                       |                                                             |                                                                                                                                                                                              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                 |                                                                                                                        |                                                                                                                                                      |                                                             |                                                                                                                                                                                              |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                 |                                                                                                                        |                                                                                                                                                      |                                                             |                                                                                                                                                                                              |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                 |                                                                                                                        |                                                                                                                                                      |                                                             |                                                                                                                                                                                              |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                 |                                                                                                                        |                                                                                                                                                      |                                                             |                                                                                                                                                                                              |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                 |                                                                                                                        |                                                                                                                                                      |                                                             |                                                                                                                                                                                              |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                               |                                                                                                                                                                                                                                                                 |                                                                                                                        |                                                                                                                                                      |                                                             |                                                                                                                                                                                              |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                |                                                                                                                                                                                                                                                                 | 28a. Date of Injury (Month, Day, Year)<br><b>June 10, 2000</b>                                                         |                                                                                                                                                      |                                                             |                                                                                                                                                                                              |
| 28b. Time of Injury<br><b>04:20 AM</b>                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                 | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                            |                                                                                                                                                      |                                                             |                                                                                                                                                                                              |
| 28d. Describe how injury occurred<br><b>House Fire</b>                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                 | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>129 N. Amity St. Baltimore, MD.</b> |                                                                                                                                                      |                                                             |                                                                                                                                                                                              |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                 |                                                                                                                        |                                                                                                                                                      |                                                             |                                                                                                                                                                                              |
| 29b. Signature and title of certifier<br><i>Kling, MD</i>                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                 | 29c. License number<br><b>RES-000</b>                                                                                  |                                                                                                                                                      | 29d. Date signed (Month, Day, Year)<br><b>JULY 14, 2000</b> |                                                                                                                                                                                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>KAREN KLING 600 N. Wolfe St. Baltimore, MD 21287</b>                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                 |                                                                                                                        |                                                                                                                                                      |                                                             |                                                                                                                                                                                              |
| 31. Date filed (Month, Day, Year)<br><b>JUL 15 2000</b>                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                 | 32. Registrar's Signature<br><i>[Signature]</i>                                                                        |                                                                                                                                                      |                                                             |                                                                                                                                                                                              |

14

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22445

|                                               |                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                                             |  |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>William George Fastie                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 2. Date of Death<br>Month Day Year<br>July 14, 2000                                                                                                                                                                                                                                                                                                                                                                           |  | 3. Time of Death<br>10:30 pm                                                                                                                                                                                                                                                                                                                |  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br>Greater Baltimore Medical Center                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 4b. City, Town, or Location of Death<br>Towson                                                                                                                                                                                                                                                                                                                                                                                |  | 4c. County of Death<br>Baltimore                                                                                                                                                                                                                                                                                                            |  |
| Funeral<br>Director                           | 5. Social Security Number<br>215-01-9809                                                                                                                                                                                                                                                                |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 7. Age (In yrs. last birthday)<br>83 Yrs.                                                                                                                                                                                                                                                                                                                                                                                     |  | 8. Date of Birth (Month, Day, Year)<br>December 6, 1916                                                                                                                                                                                                                                                                                     |  |
|                                               | 9. Birthplace (State or Foreign Country)<br>Maryland                                                                                                                                                                                                                                                    |  | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10b. County<br>Baltimore                                                                                                                                                                                                                                                                                                                                                                                                      |  | 10c. City, Town or Location<br>Baltimore                                                                                                                                                                                                                                                                                                    |  |
| To Be Completed by Funeral Director           | 10a. Street and Number<br>7110 Sheffield Rd.                                                                                                                                                                                                                                                            |  | 10f. Zip Code<br>21212                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10g. Citizen of What Country?<br>United States                                                                                                                                                                                                                                                                                                                                                                                |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                          |  |
|                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                                                                                                                                                               |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                             |  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                                                                                                                                                                                                                                                            |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>5+                                                                                                                                                                                |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>physicist                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16b. Kind of Business/Industry<br>university                                                                                                                                                                                                                                                                                                                                                                                  |  | 17. Father's Name (First, Middle, Last)<br>William F. Fastie                                                                                                                                                                                                                                                                                |  |
|                                               | 17. Mother's Name (First, Middle, Maiden Surname)<br>Carolyn Saumenig                                                                                                                                                                                                                                   |  | 19a. Informant's Name/Relationship (Type, Print)<br>William Fastie/son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7110 Sheffield Rd. Baltimore, MD 21212                                                                                                                                                                                                                                                                                       |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                             |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Thomas Church Cem.                                                                                                                                                                                                        |  | Date<br>7/18/00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  | 20c. Location - City or Town, State<br>Owings Mills, Maryland                                                                                                                                                                                                                                                                                                                                                                 |  | 21. Signature of Funeral Service Licensee<br>John D. Mitchell IV                                                                                                                                                                                                                                                                            |  |
|                                               | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Funeral Home, Inc.<br>6500 York Rd.<br>Baltimore, MD 21212                                                                                                                                                                                       |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Pneumonia<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  | Approximate Interval Between Onset and Death<br>3 days                                                                                                                                                                                                                                                                                                                                                                        |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                      |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                        |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                       |  |
|                                               | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                              |  | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                     |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                           |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>T. Jiang                                                                                                                                                                                                                                                                                           |  |
|                                               | 29c. License number<br>D54967                                                                                                                                                                                                                                                                           |  | 29d. Date signed (Month, Day, Year)<br>7/15/00                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>T. Jiang GBMC 6701 N. Charles St.                                                                                                                                                                                                                                                                                                     |  | 31. Date filed (Month, Day, Year)<br>JUL 17 2000                                                                                                                                                                                                                                                                                            |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br>B. Sparks                                                                                                                                                                                                                                                                  |  | 33. State Registrar<br>State Registrar                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020                                                                                                                                                                                                                                                                                                                                                 |  | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once. |  |
|                                               | 36. To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                       |  | 37. To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 38. To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                             |  | 39. To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                           |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22446

|                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                   |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br>YOLANDA J. FUSCO                                      |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br>July 10, 2000 |                                                                                                                                                                                                   |                                |                                                                                      | 3. Time of Death<br>11:24 A.M.   |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br>Franklin Square Hospital Center |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>Rosedale    |                                                                                                                                                                                                   |                                |                                                                                      | 4c. County of Death<br>Baltimore |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br>079-12-2091                                                          |                          | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br>84 Yrs.           |                                                                                                                                                                                                   | If Under 1 Year<br>Months Days |                                                                                      | If Under 24 Hrs.<br>Hours Min.   |                                                                                                    | 8. Date of Birth (Month, Day, Year)<br>Nov 21, 1915 |                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br>NY |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Usual Residence of Decedent                                                                       |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                   | 10b. County<br>Baltimore |                                                                                                                                                       | 10c. City, Town or Location<br>Baltimore                                                                                                                                                                                                                                                                |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                     |                                                                                                                                             |                                                |  |
| 10e. Street and Number<br>1000 Franklin Avenue #906                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                   |                          |                                                                                                                                                       | 10f. Zip Code<br>21221                                                                                                                                                                                                                                                                                  |                                                     |                                                                                                                                                                                                   |                                | 10g. Citizen of What Country?<br>USA                                                 |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                           |                                                                                                   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                         |                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                |                                                                                      |                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                   |                                                     |                                                                                                                                             |                                                |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8<br>College (1-4 or 5+) 0                                                                                                                                                                                                                                                                                                                        |                                                                                                   |                          |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>seamstress                                                                                                                                                                                 |                                                     |                                                                                                                                                                                                   |                                | 16b. Kind of Business/Industry<br>garment                                            |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
| 17. Father's Name (First, Middle, Last)<br>Pasquale Porzio                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                   |                          |                                                                                                                                                       | 18. Mother's Name (First, Middle, Maiden Surname)<br>Concetta Paradisio                                                                                                                                                                                                                                 |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Franklin Square Hospital                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                   |                          |                                                                                                                                                       | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9000 Franklin Square Dr Baltimore, MD 21237                                                                                                                                                            |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                  |                                                                                                   |                          |                                                                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)                                                                                                                                                                                                                                  |                                                     |                                                                                                                                                                                                   |                                | Data                                                                                 |                                  | 20c. Location - City or Town, State                                                                |                                                     |                                                                                                                                             |                                                |  |
| 21. Signature of Funeral Service Licensee<br>Ronald S. Wade, Director                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                   |                          |                                                                                                                                                       | 22. Name and Address of Facility<br>State Anatomy Board 655 W. Baltimore Street<br>Baltimore, MD 21201                                                                                                                                                                                                  |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Intracranial Bleed<br>Due to (or as a consequence of):<br>b. Hypertension<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |                                                                                                   |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  |                                                                                                    |                                                     | Approximate Interval Between Onset and Death<br>13 Hours                                                                                    |                                                |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Coronary Artery Disease With Coronary Artery Bypass Graft                                                                                                                                                                                                                                                              |                                                                                                   |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                                         |                                                                                                   |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                        |                                                                                                   |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  |                                                                                                    |                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                            |                                                                                                   |                          |                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                        |                                                                                                   |                          |                                                                                                                                                       | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                     | 28b. Time of Injury<br>M                                                                                                                                                                          |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                  | 28d. Describe how injury occurred                                                                  |                                                     |                                                                                                                                             |                                                |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                           |                                                                                                   |                          |                                                                                                                                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                 |                                                                                                   |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
| 29b. Signature and title of certifier<br>Yvonne Latimer MD                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                   |                          |                                                                                                                                                       | 29c. License number<br>RD 203471                                                                                                                                                                                                                                                                        |                                                     |                                                                                                                                                                                                   |                                | 29d. Date signed (Month, Day, Year)<br>07/10/00                                      |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. Yvonne Latimer 9000 Franklin Square Drive Baltimore, MD 21237                                                                                                                                                                                                                                                                                        |                                                                                                   |                          |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |
| 31. Date filed (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                   |                          |                                                                                                                                                       | 32. Registrar's Signature<br>▶                                                                                                                                                                                                                                                                          |                                                     |                                                                                                                                                                                                   |                                |                                                                                      |                                  |                                                                                                    |                                                     |                                                                                                                                             |                                                |  |





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State of Maryland / Department of Health and Mental Hygiene

00 22447

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Alethea Anna Foreacre

2. Date of Death

Month Day Year  
July 14 2000

3. Time of Death

705pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

213-36-7948

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 30, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Rosedale

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

8419 Rocky Mt. Road

10f. Zip Code

21237

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (14 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housekeeping

16b. Kind of Business/Industry

Institution

17. Father's Name (First, Middle, Last)

Arthur Franklin Foreacre

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth Whaley

19a. Informant's Name/Relationship (Type, Print)

Joseph Anastasio

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

B.A.R.C. 7215 York Rd., Towson, Md. 21212

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lake View Mem. Park July 18, 2000 Sykesville, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

H. J. Ehlhardt

22. Name and Address of Facility

Eckhardt Funeral Chapel  
11605 Reisterstown Rd., Owings Mills, Md. 2111723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

Approximate  
interval Between  
Onset and Death

6 Days

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Chronic Atrial Fibrillation

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Suicide  
☐ Homicide ☐ Could not be  
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

P. J. ...

29c. License number

DS3462

29d. Date signed (Month, Day, Year)

7/15/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. JUDE MUNESSES - 9000 Franklin Square Drive Baltimore MD 21237

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

Geneva B. Sparks

State  
Registrar

ORIGINAL

Foreacre, Alethea  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State of New York

County of ...

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22448

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MAMIE GILES

2. Date of Death

JULY 14 2000

3. Time of Death

14:33(PM)

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-02-6639

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov. 25, 1926

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Linthicum

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

620 Franklin Ave.

10f. Zip Code

21090

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
7

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Quality Control Inspector

16b. Kind of Business/Industry

Glass Manufacturing

17. Father's Name (First, Middle, Last)

William J. Martin

18. Mother's Name (First, Middle, Maiden Surname)

Mary E. Moyer

19a. Informant's Name/Relationship (Type, Print)

Benton T. Giles

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

620 Franklin Ave. Linthicum, MD. 21090

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

7-18-00

20c. Location - City or Town, State

Brooklyn Park, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Ambrose Funeral Home, Inc.  
1328 Sulphur Spring Rd. Arbutus, MD. 2122723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. MYOCARDIAL INFARCTION (REPEAT)

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

&lt; 1 day

15 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1. RENAL FAILURE

2. HYPERTENSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature] MEDICAL INTENSIVE CARE  
UNIT RESIDENT

29c. License number

P13140

29d. Date signed (Month, Day, Year)

JULY 14, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAMEER BADE MD, 3001 SOUTH HANOVER STREET, BALTIMORE, MARYLAND 21225

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
document.

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

00 22449

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Frances Laura Gedeon

2. Date of Death

Month Day Year  
July 14 2000

3. Time of Death

605 pm

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

212-30-0797

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
9/2/1932

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland Baltimore

10b. County

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

227 Southeastern Court

10f. Zip Code

21221

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Day Care

16b. Kind of Business/Industry

Child Care

17. Father's Name (First, Middle, Last)

Lawrence Bures

18. Mother's Name (First, Middle, Maiden Surname)

Frances Rites

19a. Informant's Name/Relationship (Type, Print)

Sharon Lee Butler (Daughter) 227 Southeastern Court Essex, MD 21221

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Holly Hill Memorial Gardens Middle River, MD

Date

7/18/2000

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael C. Gaffney

22. Name and Address of Facility

Bruzdinski Funeral Home PA  
1407 Old Eastern Avenue Essex, MD 21221

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastasis

Due to (or as a consequence of):

b. Breast Cancer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

4 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Anna Izquierdo-Parrera

29c. License number

RD203505

29d. Date signed (Month, Day, Year)

July 14, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Anna Izquierdo-Parrera 9000 Franklin Square Drive Baltimore Maryland 21237

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

B. Sparks

State Registrar

ORIGINAL

Division of Vital Records, P.O. Box 68760,

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Gedeon, Frances

AMY





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22450

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

David William Geppi

2. Date of Death

Month  
JulyDay  
14Year  
2000

3. Time of Death

8:21 P.M.

4a. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

215-58-2513

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

46

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 27, 1953

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8610 Silver Knoll Drive

10f. Zip Code

21128

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12 yrs.

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Fire Fighter

16b. Kind of Business/Industry

Baltimore City

17. Father's Name (First, Middle, Last)

Frank J. Geppi

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn E. Zoltowski

19a. Informant's Name/Relationship (Type, Print)

Gary Geppi - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23 Lincoln Woods Way, Perry Hall, MD 21128

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dulaney Valley Mem'l Gard, 7/19/00 Timonium, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

William G. Dau

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.  
5305 Harford Rd., Baltimore, MD 2121423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Electrocution

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)  
Found: 07-14-00

28b. Time of Injury

Found: 7:40 P.M.

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Subject struck by lightning.  
28e. Location (Street and Number or Rural Route Number,  
City or Town, State) 562 Anchor Drive  
Joppa, Maryland.28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)  
Sidewalk in front of a residence29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis Chute M.D.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chute M.D.

111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

Dennis Chute

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22451

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                       |                                          |                                                                                                                                                                                                                                                                                                         |  |                                |  |                                                                                                    |  |                                                            |  |                                                      |  |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------|--|----------------------------------------------------------------------------------------------------|--|------------------------------------------------------------|--|------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Katherine Gertrude Griefzu                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                       |                                          | 2. Date of Death<br>Month Day Year<br>July 11, 2000                                                                                                                                                                                                                                                     |  |                                |  | 3. Time of Death<br>10:12 A.M.                                                                     |  |                                                            |  |                                                      |  |
|                                                                      | 4a. Facility Name (If not institution, give street and number)<br>Good Samaritan Hospital                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |                                          | 4b. City, Town, or Location of Death<br>Baltimore                                                                                                                                                                                                                                                       |  |                                |  | 4c. County of Death<br>N/A                                                                         |  |                                                            |  |                                                      |  |
| Funeral<br>Director                                                  | 5. Social Security Number<br>218-70-7659                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                          | 7. Age (In yrs. last birthday)<br>91 Yrs.                                                                                                                                                                                                                                                               |  | If Under 1 Year<br>Months Days |  | If Under 24 Hrs.<br>Hours Min.                                                                     |  | 8. Date of Birth (Month, Day, Year)<br>9-2-1908            |  | 9. Birthplace (State or Foreign Country)<br>Maryland |  |
|                                                                      | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       |                                          |                                                                                                                                                                                                                                                                                                         |  |                                |  |                                                                                                    |  |                                                            |  |                                                      |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. County<br>Baltimore                                                                                                                              |                                          | 10c. City, Town or Location<br>Towson                                                                                                                                                                                                                                                                   |  |                                |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |                                                            |  |                                                      |  |
|                                                                      | 10e. Street and Number<br>8302 Alston Road                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |                                          | 10f. Zip Code<br>21204                                                                                                                                                                                                                                                                                  |  |                                |  | 10g. Citizen of What Country?<br>U. S. A.                                                          |  |                                                            |  |                                                      |  |
|                                                                      | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                        |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                        |  |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |                                                            |  |                                                      |  |
|                                                                      | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                       |                                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                                                                                                                                  |  |                                |  | 16b. Kind of Business/Industry<br>Own Home                                                         |  |                                                            |  |                                                      |  |
|                                                                      | 17. Father's Name (First, Middle, Last)<br>Bernard James Burke                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |                                          | 18. Mother's Name (First, Middle, Maiden Surname)<br>Katherine Fitzpatrick                                                                                                                                                                                                                              |  |                                |  |                                                                                                    |  |                                                            |  |                                                      |  |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs Joan K. Melocik (Daughter)                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                       |                                          | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8302 Alston Road, Towson, Maryland 21204                                                                                                                                                               |  |                                |  |                                                                                                    |  |                                                            |  |                                                      |  |
|                                                                      | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                               |  |                                                                                                                                                       |                                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Moreland Memorial Park                                                                                                                                                                                                        |  |                                |  | 20c. Date<br>7-15-00                                                                               |  | 20d. Location - City or Town, State<br>Parkville, Maryland |  |                                                      |  |
|                                                                      | 21. Signature of Funeral Service Licensee<br>Wallace S. Brooks, Jr.                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                       |                                          | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204                                                                                                                                                                                                   |  |                                |  |                                                                                                    |  |                                                            |  |                                                      |  |
|                                                                      | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>ACUTE MYOCARDIAL INFARCT 1 Hr                                                                                                                 |  |                                                                                                                                                       |                                          |                                                                                                                                                                                                                                                                                                         |  |                                |  |                                                                                                    |  |                                                            |  |                                                      |  |
|                                                                      | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>COPD<br>ASPIRATION PNEUMONIA<br>DIABETES MELLITUS                                                                                                                                                                                                                                              |  |                                                                                                                                                       |                                          |                                                                                                                                                                                                                                                                                                         |  |                                |  |                                                                                                    |  |                                                            |  |                                                      |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                      |  |                                                                                                                                                       |                                          |                                                                                                                                                                                                                                                                                                         |  |                                |  |                                                                                                    |  |                                                            |  |                                                      |  |
|                                                                      | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                       |                                          | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                             |  |                                |  |                                                                                                    |  |                                                            |  |                                                      |  |
|                                                                      | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                       |                                          | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                |  |                                                                                                    |  |                                                            |  |                                                      |  |
|                                                                      | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |  |                                                                                                                                                       |                                          | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |  | 28b. Time of Injury<br>M       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |  | 28d. Describe how injury occurred                          |  |                                                      |  |
|                                                                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                       |                                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                            |  |                                |  |                                                                                                    |  |                                                            |  |                                                      |  |
| State Registrar                                                      | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                                                                                                                                       |                                          |                                                                                                                                                                                                                                                                                                         |  |                                |  |                                                                                                    |  |                                                            |  |                                                      |  |
|                                                                      | 29b. Signature and title of certifier<br>L. E. Rivera MD                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                       |                                          | 29c. License number<br>008344                                                                                                                                                                                                                                                                           |  |                                |  | 29d. Date signed (Month, Day, Year)<br>7/13/00                                                     |  |                                                            |  |                                                      |  |
|                                                                      | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>L. E. RIVERA GOOD SAMARITIAN HOSPITAL BALTIMORE MARYLAND                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |                                          |                                                                                                                                                                                                                                                                                                         |  |                                |  |                                                                                                    |  |                                                            |  |                                                      |  |
| 31. Date filed (Month, Day, Year)<br>JUL 15 2000                     |                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                       | 32. Registrar's Signature<br>[Signature] |                                                                                                                                                                                                                                                                                                         |  |                                |  |                                                                                                    |  |                                                            |  |                                                      |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

08-05



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

00 22452

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) John H. Goodman Jr.  
2. Date of Death Month Day Year July 11 2000 3. Time of Death 01:22P.m.

4a. Facility Name (If not Institution, give street and number) Good Samaritan Hospital 4b. City, Town, or Location of Death Baltimore 4c. County of Death NA

Funeral  
Director

5. Social Security Number 219-40-3604 6. Sex ☒ M ☐ F 7. Age (In yrs. last birthday) 53 8. Date of Birth (Month, Day, Year) 09-10-46 9. Birthplace (State or Foreign Country) MD

Usual Residence of Decedent 10a. State MD 10b. County NA 10c. City, Town or Location Baltimore 10d. Inside City Limits ☒ Yes ☐ No

10e. Street and Number 1200 Linworth Avenue Apt. "A" 10f. Zip Code 21239 10g. Citizen of What Country? USA

11. Marital Status 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade NA 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Self employed 16b. Kind of Business/Industry Goodman Bailbonds

17. Father's Name (First, Middle, Last) John H. Goodman 18. Mother's Name (First, Middle, Maiden Surname) Josephine Durant

19a. Informant's Name/Relationship (Type, Print) Mildred Goodman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 Linworth Avenue Apt. 2A Baltimore, MD.

20a. Method of Disposition ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) King Mem.Pk. Cem. 07-17-2000 Randallstown, MD 20c. Location - City or Town, State

21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute myocardial infarction Due to (or as a consequence of): Coronary atherosclerotic arteriosclerosis

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Remote myocardial infarction, left ventricular wall Nephroarteriosclerosis 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 ☐ Yes 2 ☒ No 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier Sheldon M. Glusman M.D. 29c. License number 208734 29d. Date signed (Month, Day, Year) July 12, 2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Sheldon M. Glusman M.D. Good Samaritan Hospital 5601 Loch Raven Blvd.

31. Date filed (Month, Day, Year) JUL 15 2000 32. Registrar's Signature

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

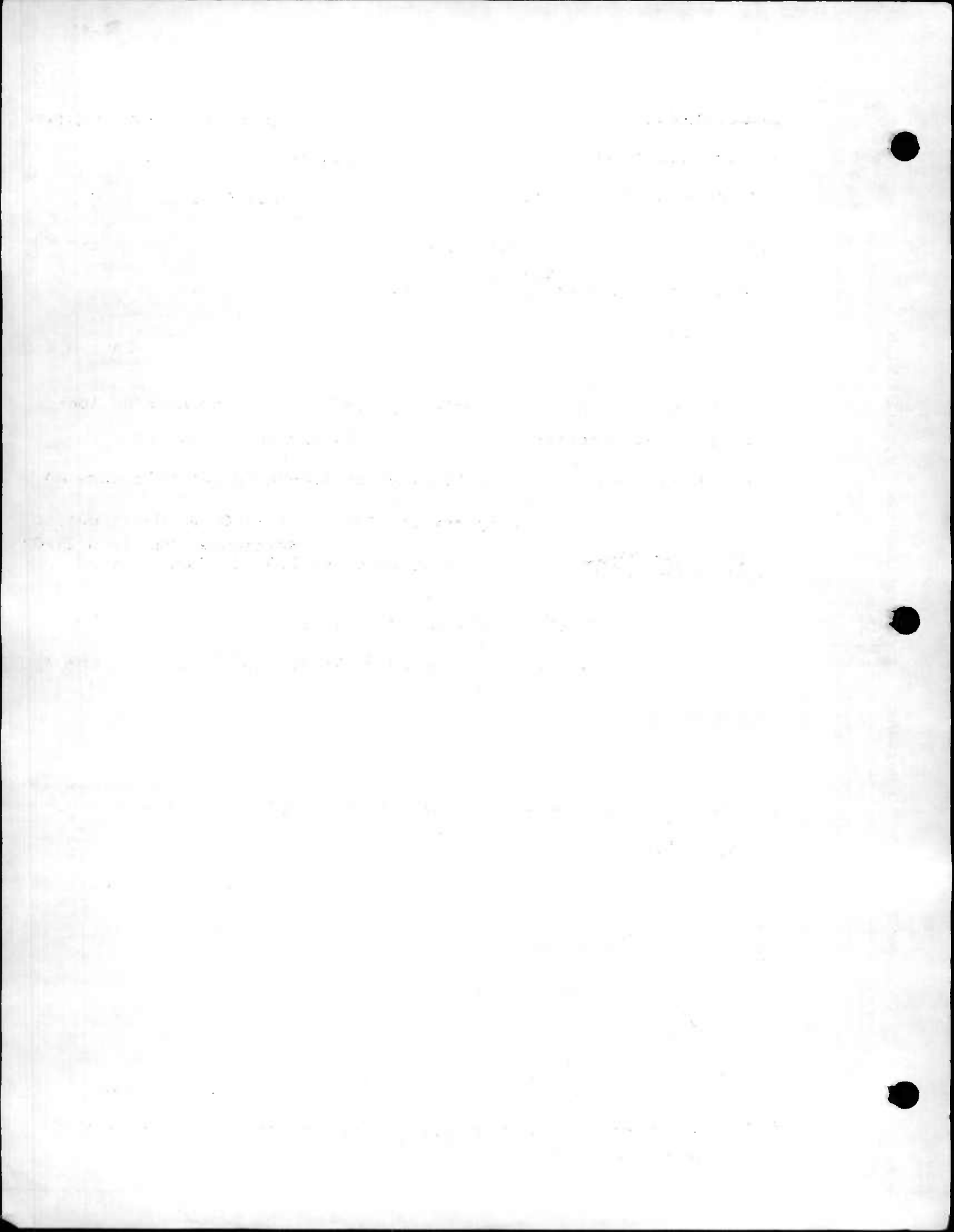
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22453  
Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                      |                                                                                      |                                                    |                                                                                                                                                                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 1. Decedent's Name (First, Middle, Last)<br>Mary K Hickox                            |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  | 2. Date of Death<br>Month Day Year<br>July 10 2000   |                                                                                      | 3. Time of Death<br>11:30PM                        |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 4a. Facility Name (If not institution, give street and number)<br>Genesis Elder Care |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  | 4b. City, Town, or Location of Death<br>Severna Park |                                                                                      | 4c. County of Death<br>Anne Arundel                |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 5. Social Security Number<br>210-09-7168                                             |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br>84                 |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>May 10 1916 |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                             |                                                                                                                                                                                                                                                                                                         | 10a. State<br>Maryland                                                         |                                                                                                                                                                                                  | 10b. County<br>Anne Arundel                          |                                                                                      | 10c. City, Town or Location<br>Pasadena            |                                                                                                                                                                                                          |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                      | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                      |                                                                                | 10e. Street and Number<br>8012 Mansion House Crossing                                                                                                                                            |                                                      | 10f. Zip Code<br>21122                                                               |                                                    | 10g. Citizen of What Country?<br>USA                                                                                                                                                                     |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                      | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |                                                    |                                                                                                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                      | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Manager                                                                                                                                                                                    |                                                                                | 16b. Kind of Business/Industry<br>Cafeteria                                                                                                                                                      |                                                      |                                                                                      |                                                    |                                                                                                                                                                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>John Fetterman                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Ford                                                                                                                                   |                                                      |                                                                                      |                                                    |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Beverly M. Utterback daughter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8012 Mansion House Crossing Pasadena, MD 21122                                                  |                                                      |                                                                                      |                                                    |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>National Memorial Park                                                                                                                                                                                                        |                                                                                | Date<br>7/15/00                                                                                                                                                                                  |                                                      | 20c. Location - City or Town, State<br>Falls Church Virginia                         |                                                    |                                                                                                                                                                                                          |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                                | 22. Name and Address of Facility<br>Stallings Funeral Home P.A.<br>3111 Mountain Road Pasadena, MD 21122                                                                                         |                                                      |                                                                                      |                                                    |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Hypoxemia Due to (or as a consequence of):<br>b. End Stage Dementia Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                      |                                                                                      |                                                    | Approximate Interval Between Onset and Death<br>1 day<br>5 years                                                                                                                                         |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                      |                                                                                      |                                                    | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                      |                                                                                      |                                                    | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                      |                                                                                      |                                                    | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                      | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                |                                                                                                                                                                                                  |                                                      |                                                                                      |                                                    |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                          |                                                                                      | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                                                | 28b. Time of Injury<br>M                                                                                                                                                                         |                                                      | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                    | 28d. Describe how injury occurred                                                                                                                                                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                |                                                                                                                                                                                                  |                                                      | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                                    |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                |                                                                                      | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                               |                                                                                | 29c. License number<br>D53462                                                                                                                                                                    |                                                      | 29d. Date signed (Month, Day, Year)<br>7/11/00                                       |                                                    |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JUDY MUNESES / GENESIS ELDER CARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                      |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                  |                                                      |                                                                                      |                                                    |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 17 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                      | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                                                |                                                                                                                                                                                                  |                                                      |                                                                                      |                                                    |                                                                                                                                                                                                          |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-2028.

Division of Vital Records, P.O. Box 68760, F

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22454

amended item# 20a per fd g785 7-26-00wj

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                              |                           |                                                                                                                                                               |                                                                                                                             |                                                                                                                                                                                              |                     |                                                                                  |                                                                                                |                                                             |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1. Decedent's Name (First, Middle, Last)<br><b>John E. Hilker</b>                            |                           |                                                                                                                                                               |                                                                                                                             | 2. Date of Death<br>Month <b>July</b> Day <b>12</b> Year <b>2000</b>                                                                                                                         |                     |                                                                                  |                                                                                                | 3. Time of Death<br><b>8:17 PM</b>                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4a. Facility Name (If not institution, give street and number)<br><b>3747 Hickory Avenue</b> |                           |                                                                                                                                                               |                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                                                                     |                     |                                                                                  |                                                                                                | 4c. County of Death<br><b>N/A</b>                           |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 5. Social Security Number<br><b>215-03-9943</b>                                              |                           | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                    |                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.                                                                                                                                             |                     | 8. Date of Birth (Month, Day, Year)<br><b>May 13, 1908</b>                       |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Usual Residence of Decedent                                                                  |                           |                                                                                                                                                               |                                                                                                                             |                                                                                                                                                                                              |                     |                                                                                  |                                                                                                |                                                             |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              | 10b. County<br><b>N/A</b> |                                                                                                                                                               | 10c. City, Town or Location<br><b>Baltimore</b>                                                                             |                                                                                                                                                                                              |                     |                                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                             |  |
| 10e. Street and Number<br><b>3747 Hickory Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              |                           |                                                                                                                                                               | 10f. Zip Code<br><b>21211</b>                                                                                               |                                                                                                                                                                                              |                     |                                                                                  | 10g. Citizen of What Country?<br><b>USA</b>                                                    |                                                             |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |                                                                                                                             | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                     |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b> College (1-4or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              |                           |                                                                                                                                                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Painter</b> |                                                                                                                                                                                              |                     |                                                                                  | 16b. Kind of Business/Industry<br><b>Interior Finishing</b>                                    |                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Spencer Hilker</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                           |                                                                                                                                                               |                                                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rachael A. Gosnell</b>                                                                                                               |                     |                                                                                  |                                                                                                |                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Louis Friedman (Attorney)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              |                           |                                                                                                                                                               |                                                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>409 Washington Ave. Ste 900 Towson, MD21204</b>                                          |                     |                                                                                  |                                                                                                |                                                             |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Pleasant Cemetery</b>                                                        |                                                                                                                             |                                                                                                                                                                                              | Date<br><b>7/17</b> |                                                                                  | 20c. Location - City or Town, State<br><b>Gamber, Maryland</b>                                 |                                                             |  |
| 21. Signature of funeral service licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |                           | 22. Name and Address of Facility<br><b>Burgee-Henss-Seitz Funeral Home, Inc<br/>3631 Falls Road, Baltimore, MD 21211</b>                                      |                                                                                                                             |                                                                                                                                                                                              |                     |                                                                                  |                                                                                                |                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                              |                           |                                                                                                                                                               |                                                                                                                             |                                                                                                                                                                                              |                     |                                                                                  |                                                                                                |                                                             |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                              |                           |                                                                                                                                                               |                                                                                                                             |                                                                                                                                                                                              |                     |                                                                                  |                                                                                                |                                                             |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                           |                                                                                                                                                               |                                                                                                                             |                                                                                                                                                                                              |                     |                                                                                  |                                                                                                |                                                             |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                           |                                                                                                                                                               |                                                                                                                             |                                                                                                                                                                                              |                     |                                                                                  |                                                                                                |                                                             |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              |                           |                                                                                                                                                               |                                                                                                                             |                                                                                                                                                                                              |                     |                                                                                  |                                                                                                |                                                             |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                |                                                                                              |                           |                                                                                                                                                               |                                                                                                                             |                                                                                                                                                                                              |                     |                                                                                  |                                                                                                |                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |                           | 28a. Date of Injury (Month, Day Year)                                                                                                                         |                                                                                                                             | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                     | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred                           |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |                           |                                                                                                                                                               |                                                                                                                             | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                     |                                                                                  |                                                                                                |                                                             |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                            |                                                                                              |                           |                                                                                                                                                               |                                                                                                                             |                                                                                                                                                                                              |                     |                                                                                  |                                                                                                |                                                             |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                           |                                                                                                                                                               |                                                                                                                             | 29c. License number<br><b>D23076</b>                                                                                                                                                         |                     | 29d. Date signed (Month, Day, Year)<br><b>7-14-00</b>                            |                                                                                                |                                                             |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RICHARD L DIAMOND 3730 Falls Rd Baltimore 21211</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              |                           |                                                                                                                                                               |                                                                                                                             |                                                                                                                                                                                              |                     |                                                                                  |                                                                                                |                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                           |                                                                                                                                                               |                                                                                                                             | 32. Registrar's Signature<br>                                                                                                                                                                |                     |                                                                                  |                                                                                                |                                                             |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

9. 11. 1941

24

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22455

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                            |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Hubert Hall, Sr.</b>                 |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month Day Year<br><b>July 09, 2000</b> |                                                                                                                                                                                              |                                |                                                                                  | 3. Time of Death<br><b>1545 pm</b>                                      |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 4a. Facility Name (If not institution, give street and number)<br><b>2828 Miles Avenue</b> |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                                                                                                                                                                              |                                |                                                                                  | 4c. County of Death<br><b>N/A</b>                                       |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 5. Social Security Number<br><b>220-38-5967</b>                                            |                           | 6. Sex<br><b>XX</b> M <input type="checkbox"/> F                                                                                                  |                                                                                                                                                                                                                                                                                                             | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.           |                                                                                                                                                                                              | If Under 1 Year<br>Months Days |                                                                                  | If Under 24 Hrs.<br>Hours Min.                                          |                                                                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>Sept 9, 1943</b> |                                                                                                                                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Usual Residence of Decedent                                                                |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
| 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                            | 10b. County<br><b>N/A</b> |                                                                                                                                                   | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                | 10d. Inside City Limits<br><b>XX</b> Yes <input type="checkbox"/> No             |                                                                         |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
| 10e. Street and Number<br><b>2828 Miles Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                            |                           |                                                                                                                                                   | 10f. Zip Code<br><b>21211</b>                                                                                                                                                                                                                                                                               |                                                            |                                                                                                                                                                                              |                                | 10g. Citizen of What Country?<br><b>USA</b>                                      |                                                                         |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                            |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                             |                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                            |                           |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Loading Dock</b>                                                                                                                                                                            |                                                            |                                                                                                                                                                                              |                                | 16b. Kind of Business/Industry<br><b>Bakery</b>                                  |                                                                         |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
| 17. Father's Name (First, Middle, Last)<br><b>John Henry Hall, Sr</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                            |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                             |                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rhoda Wolf</b>                                                                                                                       |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Dorothy Hall (Wife)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                            |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                             |                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2828 Miles Avenue, Baltimore, Maryland 21211</b>                                         |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                            |                           |                                                                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Baltimore-Washington Crematory</b>                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                | Data<br><b>7/14/00</b>                                                           |                                                                         | 20c. Location - City or Town, State<br><b>Laurel, Maryland</b>                                                                                                                                   |                                                            |                                                                                                                                                    |                                                             |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                            |                           |                                                                                                                                                   | 22. Name and Address of Facility<br><b>Burgee-Henss-Seitz Funeral Home, Inc.<br/>3631 Falls Road, Baltimore, Maryland</b>                                                                                                                                                                                   |                                                            |                                                                                                                                                                                              |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                                                                                            |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                            | Approximate Interval Between Onset and Death                                                                                                       |                                                             |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                            |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                |                                                                                  |                                                                         | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                                            |                                                                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                            |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                |                                                                                  |                                                                         | 24a. Was an autopsy performed?<br><b>Inspection</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                       |                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                             |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                            |                           |                                                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b> |                                                            |                                                                                                                                                                                              |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                            |                           |                                                                                                                                                   | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                      |                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                         | 28d. Describe how injury occurred                                                                                                                                                                |                                                            |                                                                                                                                                    |                                                             |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                            |                           |                                                                                                                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                      |                                                            |                                                                                                                                                                                              |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |                                                                         |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                          |                                                                                            |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                            |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                             |                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                       |                                | 29d. Date signed (Month, Day, Year)<br><b>July 10, 2000</b>                      |                                                                         |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br><b>Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                            |                           |                                                                                                                                                   |                                                                                                                                                                                                                                                                                                             |                                                            |                                                                                                                                                                                              |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                            |                           |                                                                                                                                                   | 32. Registrar's Signature<br>                                                                                                                                                                                           |                                                            |                                                                                                                                                                                              |                                |                                                                                  |                                                                         |                                                                                                                                                                                                  |                                                            |                                                                                                                                                    |                                                             |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

w j

State Registrar



Wm. G. Smith

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22456

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                        |                                                                                                                                                            |                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br>Mary Lou Johnson                                |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                        | 2. Date of Death<br>Month: July Day: 17 Year: 2000     |                                                                                                                                                            | 3. Time of Death<br>1240 pm                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br>Maryland General Hospital |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4b. City, Town, or Location of Death<br>Baltimore City |                                                                                                                                                            | 4c. County of Death                             |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br>226-30-5570                                                    |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                                        | 7. Age (In yrs. last birthday)<br>77 Yrs.              |                                                                                                                                                            | 8. Date of Birth (Month, Day, Year)<br>6-7-1923 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br>Va                                              |                                                                                                                                                                                                                                                                                                         | 10a. State<br>Md                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10b. County<br>N/A                                     |                                                                                                                                                            | 10c. City, Town or Location<br>Baltimore        |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                 |                                                                                             | 10e. Street and Number<br>3807 Glengyle Avenue                                                                                                                                                                                                                                                          |                                                                                | 10f. Zip Code<br>21215                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                        | 10g. Citizen of What Country?<br>U S A                                                                                                                     |                                                 |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                           |                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                      |                                                        | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                                                                           |                                                 |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th grade                                                                                                                                                                                                                                                                                                                     |                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Cook                                                                                                                                                                                       |                                                                                | 16b. Kind of Business/Industry<br>Church Home Hospital                                                                                                                                                                                                                                                                                                                                                                                 |                                                        |                                                                                                                                                            |                                                 |  |
| 17. Father's Name (First, Middle, Last)<br>Barnett Saunders                                                                                                                                                                                                                                                                                                                                                                      |                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Matthews                                                                                                                                                                                                                                      |                                                                                | 19a. Informant's Name/Relationship (Type, Print)<br>Frances Edwards- Daughter                                                                                                                                                                                                                                                                                                                                                          |                                                        | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3807 Glengyle Avenue Baltimore, Md 21215                  |                                                 |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                  |                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Garrison Forest Vet                                                                                                                                                                                                           |                                                                                | 20c. Location - City or Town, State<br>7-17-00 Owings Mills, Md                                                                                                                                                                                                                                                                                                                                                                        |                                                        |                                                                                                                                                            |                                                 |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             | 22. Name and Address of Facility<br>March F/H West<br>4300 Wabash Avenue Baltimore, Md 21215                                                                                                                                                                                                            |                                                                                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>a. Diabetes Mellitus<br>Due to (or as a consequence of):<br>b. Cerebrovascular Accident (Stroke)<br>Due to (or as a consequence of):<br>c. End Stage Renal Disease<br>Due to (or as a consequence of):<br>d. Hypertension |                                                        | Approximate Interval Between Onset and Death                                                                                                               |                                                 |  |
| 23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                      |                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown                                                                                                |                                                                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                              |                                                        | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                |                                                 |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                             | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                 |                                                        | 28a. Date of Injury (Month, Day, Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                 |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                             | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                           |                                                        |                                                                                                                                                            |                                                 |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                             | 29b. Signature and title of certifier<br><i>[Signature]</i>                                                                                                                                                                                                                                             |                                                                                | 29c. License number<br>89376                                                                                                                                                                                                                                                                                                                                                                                                           |                                                        | 29d. Date signed (Month, Day, Year)<br>7/11/00                                                                                                             |                                                 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Letha Jayakrishnan, M.D. 90 Maryland General Hospital                                                                                                                                                                                                                                                                                    |                                                                                             | 31. Date filed (Month, Day, Year)<br>JUL 17 2000                                                                                                                                                                                                                                                        |                                                                                | 32. Registrar's Signature<br><i>[Signature]</i>                                                                                                                                                                                                                                                                                                                                                                                        |                                                        |                                                                                                                                                            |                                                 |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22457

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                | 1. Decedent's Name (First, Middle, Last)<br><b>Lelah Ardeth Johnston</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                  | 2. Date of Death<br>Month Day Year<br><b>JULY 13, 2000</b>                                                                                                                                        |                                                                                      | 3. Time of Death<br><b>6:15 AM</b>                                                                                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 4a. Facility Name (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                  | 4b. City, Town, or Location of Death<br><b>Towson</b>                                                                                                                                             |                                                                                      | 4c. County of Death<br><b>Baltimore</b>                                                                                                                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                              | 5. Social Security Number<br><b>218-28-1652</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.                                                                                                                                                  |                                                                                      | 8. Date of Birth (Month, Day, Year)<br><b>October 10, 1932</b>                                                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                         | 10a. State<br><b>MD</b>                                                                                                                               |                                                                                                                  | 10b. County<br><b>---</b>                                                                                                                                                                         |                                                                                      | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                                          |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                              | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         | 10e. Street and Number<br><b>3034 Guilford Avenue</b>                                                                                                 |                                                                                                                  | 10f. Zip Code<br><b>21218</b>                                                                                                                                                                     |                                                                                      | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6 yrs.</b><br>College (1-4 or 5+) <b>College</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maid</b>                              |                                                                                                                  | 16b. Kind of Business/Industry<br><b>Cleaning Service</b>                                                                                                                                         |                                                                                      |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. Father's Name (First, Middle, Last)<br><b>Henry Dayton Fury</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lola M. Bair</b>                                                                                                                          |                                                                                      |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joseph Fury- Brother</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1225 Dulaney Valley Rd., Towson, MD 21286</b>                                                 |                                                                                      |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Loudon Park</b>                                                          |                                                                                                                  | 20c. Date<br><b>7/17/00</b>                                                                                                                                                                       |                                                                                      | 20d. Location - City or Town, State<br><b>Baltimore, MD</b>                                                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 21. Signature of Funeral Service Licensee<br> <b>William G. Dau</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                  | 22. Name and Address of Facility<br><b>Leonard J. Ruck Funeral Home, Inc.<br/>5305 Harford Rd., Baltimore, MD 21214</b>                                                                           |                                                                                      |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. PNEUMONIA</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                  |                                                                                                                                                                                                   |                                                                                      |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                  |                                                                                                                                                                                                   |                                                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                  |                                                                                                                                                                                                   |                                                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                                                                                                  |                                                                                                                                                                                                   |                                                                                      |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 28a. Date of Injury (Month, Day, Year)<br><b>M</b>                                                                                                                                                                                                                                                      |                                                                                                                                                       | 28b. Time of Injury<br><b>M</b>                                                                                  |                                                                                                                                                                                                   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                                                                                                                          |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                                                                                                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                     |                                                                                                                                                                                                   |                                                                                      |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                  |                                                                                                                                                                                                   |                                                                                      |                                                                                                                                                                                                          |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 29c. License number<br><b>D 37254</b>                                                                            |                                                                                                                                                                                                   | 29d. Date signed (Month, Day, Year)<br><b>7/15/00</b>                                |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>BOON P. LIM, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204</b>                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                  |                                                                                                                                                                                                   |                                                                                      |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 32. Registrar's Signature<br> |                                                                                                                                                                                                   |                                                                                      |                                                                                                                                                                                                          |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22458

## Certificate of Death

Reg. No.

|                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                                                                  |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Treva Kienle</b>                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                             |  | 2. Date of Death<br>Month Day Year<br><b>July 13, 2000</b>                                                                                                                                      |  | 3. Time of Death<br><b>2:30am</b>                                                           |                                                                                                                                                                                                  |
|                                               | 4a. Facility Name (If not institution, give street and number)<br><b>11 G Wind Mill Chase</b>                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                             |  | 4b. City, Town, or Location of Death<br><b>Sparks</b>                                                                                                                                           |  | 4c. County of Death<br><b>Baltimore</b>                                                     |                                                                                                                                                                                                  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-22-3722</b>                                                                                                                                                                                                                                                                                                                                                                                                               |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.                                                                                                                                                |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct 21, 1927</b>                                  |                                                                                                                                                                                                  |
|                                               | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                                                                                                                                                                                                                                   |  | 10a. State<br><b>Maryland</b>                                                                                                                                                                                                                                                               |  | 10b. County<br><b>Baltimore</b>                                                                                                                                                                 |  | 10c. City, Town or Location<br><b>Sparks</b>                                                |                                                                                                                                                                                                  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                |  | 10e. Street and Number<br><b>11 G Wind Mill Chase</b>                                                                                                                                                                                                                                       |  | 10f. Zip Code<br><b>21152</b>                                                                                                                                                                   |  | 10g. Citizen of What Country?<br><b>USA</b>                                                 |                                                                                                                                                                                                  |
|                                               | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |                                                                                                                                                                                                  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>n/a</b>                                                                                                                                                                                                                                                                                                                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Assistant Bank Manager</b>                                                                                                                                                  |  | 16b. Kind of Business/Industry<br><b>Banking</b>                                                                                                                                                |  |                                                                                             |                                                                                                                                                                                                  |
|                                               | 17. Father's Name (First, Middle, Last)<br><b>Charles Luther Allison</b>                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                             |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Marguerite Maynard</b>                                                                                                                  |  |                                                                                             |                                                                                                                                                                                                  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Eugene C. Kienle/Husband</b>                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                             |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11 G Wind Mill Chase, Sparks, MD 21152</b>                                                  |  |                                                                                             |                                                                                                                                                                                                  |
|                                               | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                         |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Druid Ridge Cemetery</b>                                                                                                                                                                                       |  | 20c. Location - City or Town, State<br><b>7/17/00 Pikesville, Maryland</b>                                                                                                                      |  | 20d. Date                                                                                   |                                                                                                                                                                                                  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Bryan W. Clay</b>                                                                                                                                                                                                                                                                                                                                                                                             |  | 22. Name and Address of Facility<br><b>Lemmon Funeral Home<br/>10 W. Padonia Road, Timonium, MD 21093</b>                                                                                                                                                                                   |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                                                                  |
|                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Colon Carcinoma</b><br>Due to (or as a consequence of):<br>a.<br>b.<br>c.<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             | Approximate Interval Between Onset and Death<br><b>3 years</b>                                                                                                                                   |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|                                               | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                             |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                                                                  |
|                                               | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                       |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                 |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                    |  |                                                                                             |                                                                                                                                                                                                  |
|                                               | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                     |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                                                                  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><b>John C. Downs MD</b>                                                                                                                                                                                                                                                                                                                                                                                              |  | 29c. License number<br><b>D33624</b>                                                                                                                                                                                                                                                        |  | 29d. Date signed (Month, Day, Year)<br><b>July 13, 2000</b>                                                                                                                                     |  |                                                                                             |                                                                                                                                                                                                  |
|                                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John C. Downs, MD 7505 Osler Dr., suite 302, Towson, MD 21204</b>                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                                                                  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                       |  | 32. Registrar's Signature<br><b>Bryana B Sparks</b>                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                 |  |                                                                                             |                                                                                                                                                                                                  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22459

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine E. Kirby

2. Date of Death  
Month Day Year06<sup>th</sup> 20 2000

3. Time of Death

5<sup>15</sup> pm.

4a. Facility Name (If not institution, give street and number)

Chapel Hill Nursing Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

218-03-4509

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
03-08-1920

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Randallstown

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4511 Robosson Road

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

housewife

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

Benjamin P. Tomlinson

18. Mother's Name (First, Middle, Maiden Surname)

Bertha E. Zink

19a. Informant's Name/Relationship (Type, Print)

Chapel Hill Nursing Center

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4511 Robosson Road Randallstown, MD 21133

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Chronic restrictive lung disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

Seizure

Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Allen J. Chenevix

29c. License number

029085

29d. Date signed (Month, Day, Year)

June 20 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Allen J. Chenevix 5310 010 Court RD 21133

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

Benjamin A. Sparks

ORIGINAL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22460

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                                            |                                                                                      |                                                                                                    |                                                     |                                                                                                                                                                                                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br>SVETLANA KODRA                                |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                | 2. Date of Death<br>Month Day Year<br>July 12, 2000        |                                                                                      |                                                                                                    | 3. Time of Death<br>11:15PM                         |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br>2300 Shaded Brook Drive |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                | 4b. City, Town, or Location of Death<br>Owings Mills       |                                                                                      |                                                                                                    | 4c. County of Death<br>Baltimore                    |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br>318-52-2647                                                  |                                                                                                                                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                          |                                                                                                                                                                                                   | 7. Age (In yrs. last birthday)<br>55 Yrs.                                                                                                      |                                                            | 8. Date of Birth (Month, Day, Year)<br>December 2, 1944                              |                                                                                                    | 9. Birthplace (State or Foreign Country)<br>Romania |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                               |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                | 10. City, Town or Location<br>Owings Mills                 |                                                                                      | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                     |                                                                                                                                                                                                          |  |
| 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                           | 10b. County<br>Baltimore                                                                                                                              |                                                                                                                                                                                                                                                                                                         | 10c. City, Town or Location<br>Owings Mills                                                                                                                                                       |                                                                                                                                                | 10f. Zip Code<br>21117                                     |                                                                                      | 10g. Citizen of What Country?<br>USA                                                               |                                                     |                                                                                                                                                                                                          |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                                                                                                                                                                                         | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |                                                                                                    |                                                     |                                                                                                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Esthetician                                                                          |                                                                                                                                                |                                                            | 16b. Kind of Business/Industry<br>Skin Care                                          |                                                                                                    |                                                     |                                                                                                                                                                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>Achim George Nicolaevici                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Raisa Kravtova                                                                            |                                                            |                                                                                      |                                                                                                    |                                                     |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Diana Gavilla Sister                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2300 Shaded Brook Drive Owings Mills Md 21117 |                                                            |                                                                                      |                                                                                                    |                                                     |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                              |                                                                                           |                                                                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Greenmount Cemetery                                                                                                                                                                                                           |                                                                                                                                                                                                   |                                                                                                                                                | 20c. Location - City or Town, State<br>Baltimore, Maryland |                                                                                      | 20d. Date<br>7/14/00                                                                               |                                                     |                                                                                                                                                                                                          |  |
| 21. Signature of Funeral Service/Licensee<br><i>Dennis Stasha Kenaker</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   | 22. Name and Address of Facility<br>Mitchell-Wiedefeld Funeral Home Inc.<br>6500 York Road Baltimore, Maryland 21212                           |                                                            |                                                                                      |                                                                                                    |                                                     |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>metastatic colon carcinoma</u><br>Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                                            |                                                                                      |                                                                                                    |                                                     | Approximate Interval Between Onset and Death<br>2 years                                                                                                                                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                                            |                                                                                      |                                                                                                    |                                                     | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                                            |                                                                                      |                                                                                                    |                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                           |                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                   |                                                                                                                                                |                                                            |                                                                                      |                                                                                                    |                                                     |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                          |                                                                                           |                                                                                                                                                       | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                   | 28b. Time of Injury<br>M                                                                                                                       |                                                            | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                    | 28d. Describe how injury occurred                   |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                           |                                                                                                                                                       | 29b. Signature and title of certifier<br><i>Marvin J. Feldman MD</i>                                                                                                                                                                                                                                    |                                                                                                                                                                                                   |                                                                                                                                                |                                                            |                                                                                      |                                                                                                    |                                                     |                                                                                                                                                                                                          |  |
| 29c. License number<br>D07930                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                           |                                                                                                                                                       | 29d. Date signed (Month, Day, Year)<br>July 13, 2000                                                                                                                                                                                                                                                    |                                                                                                                                                                                                   |                                                                                                                                                |                                                            |                                                                                      |                                                                                                    |                                                     |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Marvin J. Feldman 300 St Paul St Baltimore, Maryland 21202                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                           |                                                                                                                                                       |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                   |                                                                                                                                                |                                                            |                                                                                      |                                                                                                    |                                                     |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 15 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                           |                                                                                                                                                       | 32. Registrar's Signature<br><i>Sparks</i>                                                                                                                                                                                                                                                              |                                                                                                                                                                                                   |                                                                                                                                                |                                                            |                                                                                      |                                                                                                    |                                                     |                                                                                                                                                                                                          |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22461

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Stephanie

2. Date of Death

June 10 2000

3. Time of Death

15:00

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

5. Social Security Number

216-57-4894

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

0

8. Date of Birth (Month, Day, Year)

MARCH 23, 00

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD.

10b. County

PITTSVILLE

10c. City, Town or Location

PITTSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3445 TINGLE ROAD

10f. Zip Code

21850

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: KOREAN

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

MAN KIM

18. Mother's Name (First, Middle, Maiden Surname)

SON SONG

19a. Informant's Name/Relationship (Type, Print)

MR. MAN KIM- FATHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3445 TINGLE ROAD PITTSVILLE, MARYLAND 20850

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HOLLTOP SERVICE CORP.

Date

6/16/00

20c. Location - City or Town, State

TOWNSON, MARYLAND

21. Signature of Funeral Service Licensee

HEATHER CAIN

PER. DVR.

22. Name and Address of Facility

LEONARD J. RUCK, INC.

5305 HARFORD ROAD BALTIMORE MARYLAND 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

SEPSIS

Due to (or as a consequence of):

b.

CONGENITAL ADRENAL HYPOPLASIA

Due to (or as a consequence of):

c.

CHRONIC LUNG DISEASE

Due to (or as a consequence of):

d.

PREMATURITY

Approximate Interval Between Onset and Death

4 days

78 days

50 days

78 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

AMBIGUOUS GENITALIA

THROMBOCYTOPENIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Lawrence

29c. License number

D0054309

29d. Date signed (Month, Day, Year)

JUNE 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDWARD LAWSON 600 N. Wolfe St. Baltimore MD 21287

31. Date filed (Month, Day, Year)

JUL 15 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22462

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Liller

2. Date of Death

Month Day Year  
06 03 2000

3. Time of Death

0334

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

184-30-5526

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 26, 1937

9. Birthplace (State or Foreign Country)

WV

Usual Residence of Decedent

10a. State

VA

10b. County

N/A

10c. City, Town or Location

Alexandria

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

Radcliffe Dr.

10f. Zip Code

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Painter

16b. Kind of Business/Industry

Contractor

17. Father's Name (First, Middle, Last)

Ellsworth Liller

18. Mother's Name (First, Middle, Maiden Surname)

Virginia Shillinburgh

19a. Informant's Name/Relationship (Type, Print)

Virginia Bogaert

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

306 13th St., Monaca, PA 15061

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory

Date

06/05/00

20c. Location - City or Town, State

Catonsville, MD

21. Signature of Funeral Service Licensee

Wesley Charf

22. Name and Address of Facility

Chavis Funeral Home, P.A., 2007-09 Eastern Av.  
Baltimore, MD 21231 - (410) 342-7400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myocardial Infarction

Due to (or as a consequence of):

c. Coronary Artery Disease

Due to (or as a consequence of):

d. Anoxic Brain Injury

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Brian Hill, M.D.

29c. License number

Au4176435H10011

29d. Date signed (Month, Day, Year)

06/03/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian Hill, M.D.

21 S. Greene St., Baltimore, MD

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22463

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                           |                                                                                                                                             |                                                            |                                                                                 |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|---------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><b>MABEL LITSINGER</b>                                |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br><b>07 - 10 - 00</b> |                                                                                                                                             | 3. Time of Death<br><b>12:45 PM</b>                        |                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br><b>ALICE HANOR NURSING HOME</b> |                                                                                                                                                                                                                                                                                                         |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |                                                                                                                                             | 4c. County of Death<br><b>Baltimore</b>                    |                                                                                 |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><b>214-22-8493</b>                                                   |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.          |                                                                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>Mar. 9, 1910</b> |                                                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 9. Birthplace (State or Foreign Country)<br><b>Kentucky</b>                                       |                                                                                                                                                                                                                                                                                                         | 10a. State<br><b>Maryland</b>                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                         | 10b. County<br><b>N/A</b>                                 |                                                                                                                                             | 10c. City, Town or Location<br><b>Baltimore</b>            |                                                                                 |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                        |                                                                                | 10e. Street and Number<br><b>2065 Druid Park Drive</b>                                                                                                                                                                                                                                                                                                                                                                                  |                                                           | 10f. Zip Code<br><b>21211</b>                                                                                                               |                                                            | 10g. Citizen of What Country?<br><b>USA</b>                                     |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                        |                                                                                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                        |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                     |                                                            |                                                                                 |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b></b>                                                                                                                                                                                                                                                                                     |                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Seamstress</b>                                                                                                                                                                          |                                                                                | 16b. Kind of Business/Industry<br><b>Clothing Industry</b>                                                                                                                                                                                                                                                                                                                                                                              |                                                           | 17. Father's Name (First, Middle, Last)<br><b>William Nicholas Felty</b>                                                                    |                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Myrtie Lou Williams</b> |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Brenda Mumau (Granddaughter)</b>                                                                                                                                                                                                                                                                                                                                       |                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2174 Druid Park Drive, Baltimore, Maryland 21211</b>                                                                                                                                                |                                                                                | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                         |                                                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glen Haven Memorial</b>                                        |                                                            | 20c. Location - City or Town, State<br><b>7/14/00 Glen Burnie, Maryland</b>     |  |
| 21. Signature of Funeral Service Licensee<br><b>Burpee-Henss-Seitz Funeral Home, Inc. 21211</b>                                                                                                                                                                                                                                                                                                                               |                                                                                                   | 22. Name and Address of Facility<br><b>3631 Falls Road, Baltimore, Maryland</b>                                                                                                                                                                                                                         |                                                                                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <b>Cardiopulmonary arrest</b><br>Due to (or as a consequence of):<br>b. <b>Congestive Heart Failure</b><br>Due to (or as a consequence of):<br>c. <b>Diabetes</b><br>Due to (or as a consequence of):<br>d. <b></b> |                                                           | Approximate Interval Between Onset and Death                                                                                                |                                                            |                                                                                 |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                        |                                                                                                   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                |                                                                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                               |                                                           | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                            |                                                                                 |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                  |                                                           | 28a. Date of Injury (Month, Day, Year)<br><b></b>                                                                                           |                                                            | 28b. Time of Injury<br><b>M</b>                                                 |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                          |                                                                                                   | 28d. Describe how injury occurred<br><b></b>                                                                                                                                                                                                                                                            |                                                                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b></b>                                                                                                                                                                                                                                                                                                                                       |                                                           | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b></b>                                                     |                                                            |                                                                                 |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                   | 29b. Signature and title of certifier<br><b>H. Devadoss M.D.</b>                                                                                                                                                                                                                                        |                                                                                | 29c. License number<br><b>D20146</b>                                                                                                                                                                                                                                                                                                                                                                                                    |                                                           | 29d. Date signed (Month, Day, Year)<br><b>07/10/00</b>                                                                                      |                                                            |                                                                                 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>H. Devadoss M.D.</b>                                                                                                                                                                                                                                                                                                               |                                                                                                   | 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                 |                                                                                | 32. Registrar's Signature<br><b>B. Sparks</b>                                                                                                                                                                                                                                                                                                                                                                                           |                                                           |                                                                                                                                             |                                                            |                                                                                 |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

amend item 29a per verbal response G790 12/5/00 yf

Certificate of Death

Reg. No.

00 22464

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES ELMUS LEWIS, SR.

2. Date of Death

Month Day Year  
July 10, 2000

3. Time of Death

5:15am

4a. Facility Name (If not institution, give street and number)

VAMHCS Fort Howard Division

4b. City, Town, or Location of Death

Fort Howard

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

231220692

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74

8. Date of Birth

Month Day Year

9. Birthplace (State or Foreign Country)

05-06-26

10. Inside City Limits

1 ☒ Yes 2 ☐ No

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10e. Street and Number

2503 VIOLET AVE. #1309S

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
11 TH GRADE

College (1-4or 5+)  
N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

AIRPLANE MAINT.

17. Father's Name (First, Middle, Last)

ASHTON P. LEWIS

18. Mother's Name (First, Middle, Maiden Surname)

GEORGINA STODIVANT

19a. Informant's Name/Relationship (Type, Print)

HELEN LEWIS WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2503 VIOLET AVE #1309S, BALTO. MD. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CHURCH CEMETERY 7-14-00

Date

20c. Location - City or Town, State

DUNDAS, VA

21. Signature of Funeral Service Licensee

*Wayne C. H.*

22. Name and Address of Facility

VAUGHN C. GREENE FUNERAL SERVICE  
551 BALTO. NATL PIKE BALTO. MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. High Grade Glioma

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Optic Nerve Tumor

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Sh. Sh.*

29c. License number

057235

29d. Date signed (Month, Day, Year)

June 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh Shandelya, MD. 9600 North Point Road, Fort Howard, MD 21052

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

*Sparks*

State Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Name: James E. Lewis  
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





00 22465

DMMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

00 22466

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |             |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                   |                                |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 1. Decedent's Name (First, Middle, Last)<br>Mildred Louvenia Lennon                          |             |                                                                                |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br>July 9, 2000 |                                                                                                                                                                                                   |                                |                                                                                      | 3. Time of Death<br>1:26 P.M.                        |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 4a. Facility Name (If not institution, give street and number)<br>Southern Maryland Hospital |             |                                                                                |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>Clinton    |                                                                                                                                                                                                   |                                |                                                                                      | 4c. County of Death<br>Prince George's               |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 5. Social Security Number<br>172-22-8084                                                     |             | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br>74 Yrs.          |                                                                                                                                                                                                   | If Under 1 Year<br>Months Days |                                                                                      | If Under 24 Hrs.<br>Hours Min.                       |                                                                                                                                                                                                          | 8. Date of Birth (Month, Day, Year)<br>Oct. 10, 1925 |                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br>Trenton, NJ |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Usual Residence of Decedent                                                                  |             |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                   |                                |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
| 10a. State<br>D.C.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              | 10b. County |                                                                                | 10c. City, Town or Location<br>Washington                                                                                                                                                                                                                                                               |                                                    |                                                                                                                                                                                                   |                                |                                                                                      |                                                      | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                       |                                                      |                                                                                                                                             |                                                         |  |
| 10e. Street and Number<br>3985 1ST Street, S.W.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |             |                                                                                | 10f. Zip Code<br>20032                                                                                                                                                                                                                                                                                  |                                                    |                                                                                                                                                                                                   |                                | 10g. Citizen of What Country?<br>U.S.A.                                              |                                                      |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              |             |                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                |                                                                                      |                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                                                                                                                                         |                                                      |                                                                                                                                             |                                                         |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |             |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                                                                                                                                  |                                                    |                                                                                                                                                                                                   |                                | 16b. Kind of Business/Industry<br>Private                                            |                                                      |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
| 17. Father's Name (First, Middle, Last)<br>Colonel Lennon                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              |             |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    | 18. Mother's Name (First, Middle, Maiden Surname)<br>Letha Davis Cromartie                                                                                                                        |                                |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Caroline Kellem Daughter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              |             |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1401 Hopeland Road, Wyncote, PA 19095                                                            |                                |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |             |                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lennon Cemetery                                                                                                                                                                                                               |                                                    | Date<br>7/15/00                                                                                                                                                                                   |                                | 20c. Location - City or Town, State<br>Columbus, NC                                  |                                                      |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
| 21. Signature of Funeral Service Licensee<br>CC0348                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              |             |                                                                                | 22. Name and Address of Facility<br>Latney's Funeral Home, Inc.,<br>3831 Georgia Ave., NW, Wash., DC 20011                                                                                                                                                                                              |                                                    |                                                                                                                                                                                                   |                                |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <u>Pneumonia</u><br>Due to (or as a consequence of):<br>b. <u>End Stage Renal Dis</u><br>Due to (or as a consequence of):<br>c. <u>Septicemia</u><br>Due to (or as a consequence of):<br>d. <u>Sacral Abscess</u><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |                                                                                              |             |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                   |                                |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                      | Approximate Interval Between Onset and Death                                                                                                |                                                         |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              |             |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                   |                                |                                                                                      |                                                      | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                      |                                                                                                                                             |                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |             |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                   |                                |                                                                                      |                                                      | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                                      | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                         |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |             |                                                                                | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                    |                                                                                                                                                                                                   |                                |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              |             |                                                                                | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                    | 28b. Time of Injury<br>M                                                                                                                                                                          |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                      | 28d. Describe how injury occurred                                                                                                                                                                        |                                                      |                                                                                                                                             |                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |             |                                                                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                    |                                                                                                                                                                                                   |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |                                                      |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                      |                                                                                              |             |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                   |                                |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              |             |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    | 29c. License number<br>D25640                                                                                                                                                                     |                                |                                                                                      | 29d. Date signed (Month, Day, Year)<br>July 13, 2000 |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>K. Davachi, MD 1328 Southern Ave., SE, Wash., DC 20032                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |             |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                   |                                |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |
| 31. Date filed (Month, Day, Year)<br>JUL 15 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              |             |                                                                                | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                    |                                                                                                                                                                                                   |                                |                                                                                      |                                                      |                                                                                                                                                                                                          |                                                      |                                                                                                                                             |                                                         |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit case.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22467

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CORNELIA MCGHEE

2. Date of Death  
Month Day Year  
JULY 15 20003. Time of Death  
2321

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL

4b. City, Town, or Location of Death

RANDALLSTOWN

4c. County of Death

BALTO.

Funeral  
Director

5. Social Security Number

214-24-3275-A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
11-22-1906

9. Birthplace (State or Foreign Country)

VA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

RANDALLSTOWN

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3829 KILBURN RD

10f. Zip Code

21133

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

TECHNICIAN

16b. Kind of Business/Industry

HEALTH

17. Father's Name (First, Middle, Last)

HENRY JONES

18. Mother's Name (First, Middle, Maiden Summa)

IDA BRANDON

19a. Informant's Name/Relationship (Type, Print)

GLORIA BRISTOL/CARETAKER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3829 KILBURN RD RANDALLSTOWN, MD. 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD NAT'L MEM PARK

Date

7/21/2000

20c. Location - City or Town, State

LAUREL, MD

21. Signature of Funeral Service Licensee

James A. Morton

22. Name and Address of Facility

JAMES A. MORTON &amp; SONS F.H., INC

1701 LAURENS ST. BALTO., MD. 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOPULMONARY ARREST

Due to (or as a consequence of):

b. CAD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician:To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Laura J. Haruan

29c. License number

H0051339

29d. Date signed (Month, Day, Year)

July 15, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Laura J. Haruan NWHC 5401 ad Ct. Rd. Randallstown, MD 21133

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

Benita B. Smith

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22468

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>Jacqueline Maureen Miller</b>                                                                                                                                                               |  |                                                                                                                                                   |  | 2. Date of Death<br>Month <b>July</b> Day <b>14</b> Year <b>2000</b>                                                                                                                         |  | 3. Time of Death<br><b>10:30 PM</b>                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>5 Terrace Road</b>                                                                                                                                                    |  |                                                                                                                                                   |  | 4b. City, Town, or Location of Death<br><b>Essex</b>                                                                                                                                         |  | 4c. County of Death<br><b>Baltimore</b>                                 |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>215-54-3759</b>                                                                                                                                                                                            |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br><b>51</b> Yrs.                                                                                                                                             |  | 8. Date of Birth (Month, Day, Year)<br><b>11/17/1948</b>                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                                                                                                                                |  | 10a. State<br><b>Maryland</b>                                                                                                                     |  | 10b. County<br><b>Baltimore</b>                                                                                                                                                              |  | 10c. City, Town or Location<br><b>Essex</b>                             |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                          | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                             |  | 10e. Street and Number<br><b>5 Terrace Road</b>                                                                                                   |  | 10f. Zip Code<br><b>21221</b>                                                                                                                                                                |  | 10g. Citizen of What Country?<br><b>U. S. A.</b>                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                             |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>Reporter</b>                                                                                               |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Reporter</b>                      |  | 16b. Kind of Business/Industry<br><b>Newspaper</b>                                                                                                                                           |  |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 17. Father's Name (First, Middle, Last)<br><b>James Oliver Staggs</b>                                                                                                                                                                      |  |                                                                                                                                                   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Josephine Holiday</b>                                                                                                       |  |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 19a. Informant's Name/Relationship (Type, Print)<br><b>Saville Wilson Miller (Husband)</b>                                                                                                                                                 |  |                                                                                                                                                   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5 Terrace Road Essex, Maryland 21221</b>                                                 |  |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)      |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Green Mount Crematorium</b>                                          |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                                                                                                                            |  | 20d. Date<br><b>7/15 2000</b>                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br><i>Michael C. Jaffan</i>                                                                                                                                                                      |  |                                                                                                                                                   |  | 22. Name and Address of Facility<br><b>Bruzdinski Funeral Home PA<br/>1407 Old Eastern Avenue Essex, Maryland 21221</b>                                                                      |  |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Metastatic Lung Cancer</b> |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23b. Approximate Interval Between Onset and Death<br><b>1 year</b>                                                                                                                                                                         |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23c. Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):                                                                                 |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                                                                                                                                                                                                  |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                  |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                      |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>7/15/00</b>                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 29b. Signature and title of certifier<br><i>Michael C. Jaffan MD.</i>                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 29c. License number<br><b>D22503</b>                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 29d. Date signed (Month, Day, Year)<br><b>7/15/00</b>                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>404 Eastern Blvd. Essex, Md. 21221</b>                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |
| 32. Registrar's Signature<br><i>B. Sparks</i>                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                            |  |                                                                                                                                                   |  |                                                                                                                                                                                              |  |                                                                         |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 22469

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lester Hall Miles

2. Date of Death

Month Day Year  
July 13 2000

3. Time of Death

11:49 pm

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

234-10-1418

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 7 1912

9. Birthplace (State or Foreign Country)

W. Virginia

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

300 International Circle

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: '41-'46

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Communications Coordinator

16b. Kind of Business/Industry

Exxon

17. Father's Name (First, Middle, Last)

Charles F. Miles

18. Mother's Name (First, Middle, Maiden Surname)

Stella Comba

19a. Informant's Name/Relationship (Type, Print)

Richard E. Linder/POA

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

600 Fairmount Ave., Suite 106, Towson, MD 21286

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Odd Fellows Cemetery

Date

7/17/00

20c. Location - City or Town, State

Clarksburg, W.VA

21. Signature of Funeral Service Liaison

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home  
10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Interior Myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural ☐ Pending investigation  
2 ☐ Accident ☐ Suicide  
3 ☐ Suicide ☐ Could not be determined  
4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Thomas Guarnieri, M.D.

29c. License number

D38334

29d. Date signed (Month, Day, Year)

7-14-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas Guarnieri 6505 N. Charles

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

B. Sparks

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22470

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CONSTANCE PAULINE MARION

2. Date of Death

Month Day Year  
July 13 2000

3. Time of Death

9:00AM

4a. Facility Name (If not institution, give street and number)

Manor Care Ruxton

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-36-7629

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
November 3 1915

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Towson

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

321 Worthington Road

10f. Zip Code

21286

10g. Citizen of What Country?

Canada

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Thomas

Lawton

18. Mother's Name (First, Middle, Maiden Summa)

Gertrude

Ormandy

19a. Informant's Name/Relationship (Type, Print)

Michael T. Marion (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6204 Gernand Road Baltimore, Maryland 21209

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Green Mount Crematory

Date

7/18/00

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Steven T. Bittle

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.  
6500 York Road Baltimore, Maryland 2121223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute B Hemispheric CVA

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes  
Hypertension  
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. George Wiener MD

29c. License number

DZ6475

29d. Date signed (Month, Day, Year)

7/13/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. George Wiener 9512 Harford Rd

31. Date filed (Month, Day, Year)

JUL 15 2000

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at 0000.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22471

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                            |                                |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|----------------------------------------------------------------------------------------------------|----------------------------------------|------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br>Lovell Montgomery                              |                                |                                                                                |                                                                                                                                                                                                                                                                                                         | 2. Date of Death<br>Month Day Year<br>July 3, 2000 |                                                                                                                                                                                                  |                                |                                                                                                    | 3. Time of Death<br>1:59 P.M.          |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br>Laurel Regional Hospital |                                |                                                                                |                                                                                                                                                                                                                                                                                                         | 4b. City, Town, or Location of Death<br>Laurel     |                                                                                                                                                                                                  |                                |                                                                                                    | 4c. County of Death<br>Prince George's |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br>424-12-1013                                                   |                                | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                                         | 7. Age (In yrs. last birthday)<br>80 Yrs.          |                                                                                                                                                                                                  | If Under 1 Year<br>Months Days |                                                                                                    | If Under 24 Hrs.<br>Hours Min.         |                                                                  | 8. Date of Birth (Month, Day, Year)<br>April 16, 1920 |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br>Lincoln, ALA |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                |                                |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                            | 10b. County<br>Prince George's |                                                                                | 10c. City, Town or Location<br>Laurel                                                                                                                                                                                                                                                                   |                                                    |                                                                                                                                                                                                  |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
| 10e. Street and Number<br>9000 Briarcroft Lane                                                                                                                                                                                                                                                                                                                                                                               |                                                                                            |                                |                                                                                | 10f. Zip Code<br>20708                                                                                                                                                                                                                                                                                  |                                                    |                                                                                                                                                                                                  |                                | 10g. Citizen of What Country?<br>U.S.A.                                                            |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced                                                                                                                                                                                                                                       |                                                                                            |                                |                                                                                | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                |                                                                                                    |                                        | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |                                                       |                                                                                                                                                                                                          |                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                        |                                                                                            |                                |                                                                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Govt. Printing Office Worker                                                                                                                                                               |                                                    |                                                                                                                                                                                                  |                                | 16b. Kind of Business/Industry<br>US Govt.                                                         |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>Roosevelt Pearson                                                                                                                                                                                                                                                                                                                                                                 |                                                                                            |                                |                                                                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Johnnie Montgomery                                                                                                                                                                                                                                 |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Lorraine Montgomery-Hayes-daughter                                                                                                                                                                                                                                                                                                                                       |                                                                                            |                                |                                                                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>917 Evarts Street, NE, Wash., DC 20019-1727                                                                                                                                                            |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                              |                                                                                            |                                |                                                                                | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Harmony Memorial Park                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                | Date<br>7/10/00                                                                                    |                                        | 20c. Location - City or Town, State<br>Landover, MD              |                                                       |                                                                                                                                                                                                          |                                                          |  |
| 21. Signature of Funeral Service Licensee<br> CC0348                                                                                                                                                                                                                                                                                       |                                                                                            |                                |                                                                                | 22. Name and Address of Facility<br>Latney's Funeral Home, Inc.<br>3831 Georgia Ave., NW, Wash., DC 20011                                                                                                                                                                                               |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                    |                                                                                            |                                |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                        |                                                                  |                                                       | Approximate Interval Between Onset and Death                                                                                                                                                             |                                                          |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. Myocardial Infarction<br>Due to (or as a consequence of):<br>b. Artherosclerotic Cardiovascular Disease<br>Due to (or as a consequence of):<br>c. Insulin Dependent Diabetes Mellitus<br>Due to (or as a consequence of):<br>d.                                                                                                                        |                                                                                            |                                |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Peripheral Vascular Disease                                                                                                                                                                                                                                                                        |                                                                                            |                                |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                        |                                                                  |                                                       | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |                                                          |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                    |                                                                                            |                                |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                        |                                                                  |                                                       | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                                          |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                        |                                                                                            |                                |                                                                                | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                       |                                                                                            |                                |                                                                                | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                    | 28b. Time of Injury<br>M                                                                                                                                                                         |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |                                        | 28d. Describe how injury occurred                                |                                                       |                                                                                                                                                                                                          |                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                            |                                |                                                                                | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                  |                                                    |                                                                                                                                                                                                  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                            |                                |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                 |                                                                                            |                                |                                                                                | 29c. License number<br>D24035                                                                                                                                                                                                                                                                           |                                                    |                                                                                                                                                                                                  |                                | 29d. Date signed (Month, Day, Year)<br>July 5, 2000                                                |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
| 30. Name and Address of person who completed cause of death (Item 23a) (Type, Print)<br>G. Machado, MD 321 Prince George Street, Laurel, MD 20707                                                                                                                                                                                                                                                                            |                                                                                            |                                |                                                                                |                                                                                                                                                                                                                                                                                                         |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 15 2000                                                                                                                                                                                                                                                                                                                                                                             |                                                                                            |                                |                                                                                | 32. Registrar's Signature<br>                                                                                                                                                                                        |                                                    |                                                                                                                                                                                                  |                                |                                                                                                    |                                        |                                                                  |                                                       |                                                                                                                                                                                                          |                                                          |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22472

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                    |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                                                                                                             |                                                                                                                                                                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|-------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Edna L. Nelson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                    | 2. Date of Death<br>Month Day Year<br>July 14, 2000                                                                                                                                              |                                                                                      |                                                       |                                                                                                                                             | 3. Time of Death<br>12:25pm                                                                                                                                                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>St. Elizabeth Nursing Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                    | 4b. City, Town, or Location of Death<br>Baltimore                                                                                                                                                |                                                                                      |                                                       |                                                                                                                                             | 4c. County of Death<br>N/A                                                                                                                                                                               |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>215-03-9581                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                         | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                                                                    | 7. Age (In yrs. last birthday)<br>80 Yrs.                                                                                                                                                        |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>March 10, 1920 |                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br>MD                                                                                                                                                           |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                    |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                                                                                                             |                                                                                                                                                                                                          |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br>FL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                         | 10b. County<br>Hernando                                                                                                                               |                                                                                                                    | 10c. City, Town or Location<br>Springhill                                                                                                                                                        |                                                                                      |                                                       |                                                                                                                                             | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br>4220 Bayridge Ct.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                    | 10f. Zip Code<br>34606                                                                                                                                                                           |                                                                                      | 10g. Citizen of What Country?<br>USA                  |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                    | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                      |                                                       | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                            |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Clerk |                                                                                                                                                                                                  |                                                                                      | 16b. Kind of Business/Industry<br>Car Dealership      |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>William Morgan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                    |                                                                                                                                                                                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Estelle Nowack                  |                                                       |                                                                                                                                             |                                                                                                                                                                                                          |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                                 | 19a. Informant's Name/Relationship (Type, Print)<br>Gwendolyn Krug, daughter                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                    | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5200 Larkin Rd. Arbutus, MD. 21227                                                              |                                                                                      |                                                       |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Loudon Park Cemetery                                                        |                                                                                                                    | Date<br>7-17-00                                                                                                                                                                                  |                                                                                      | 20c. Location - City or Town, State<br>Baltimore, MD  |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                    | 22. Name and Address of Facility<br>Ambrose Funeral Home, Inc.<br>1328 Sulphur Spring Rd. Arbutus, MD. 21227                                                                                     |                                                                                      |                                                       |                                                                                                                                             |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Esophageal Cancer with liver Metastasis<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                    |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                                                                                                             | Approximate Interval Between Onset and Death<br>7 month                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                    |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                                                                                                             | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                    |                                                                                                                                                                                                  |                                                                                      |                                                       | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                                                                                                                                                          |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                                                                                                                                       |                                                                                                                    |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                                                                                                             |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                  |                                                                                                                                                       | 28b. Time of Injury<br>M                                                                                           |                                                                                                                                                                                                  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                       | 28d. Describe how injury occurred                                                                                                           |                                                                                                                                                                                                          |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                               |                                                                                                                                                       | 29c. License number<br>D0055-391                                                                                   |                                                                                                                                                                                                  | 29d. Date signed (Month, Day, Year)<br>07/14/2000                                    |                                                       |                                                                                                                                             |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>MING YI 210 Business Center Drive, Reisterstown Maryland 21136                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                         |                                                                                                                                                       |                                                                                                                    |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                                                                                                             |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUL 17 2000                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                                                                                                                       |                                                                                                                    |                                                                                                                                                                                                  |                                                                                      |                                                       |                                                                                                                                             |                                                                                                                                                                                                          |  |

Charles F. Hall

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22473

## Certificate of Death

Reg. No.

Amended item #25 per ME g785 7-31-00 wj

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIAN K. PEMBERTON

2. Date of Death

Month Day Year  
JULY 10 2000

3. Time of Death

1:00 PM

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

212-01-5831

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 8, 1912

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2908 Topaz Road

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

secretary

16b. Kind of Business/Industry

canning corporation

17. Father's Name (First, Middle, Last)

Paul T. Johnson

18. Mother's Name (First, Middle, Maiden Summa)

Mary Ann Kiley

19a. Informant's Name/Relationship (Type, Print)

Phillip Pemberton/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2908 Topaz Road Baltimore, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade

Director

22. Name and Address of Facility

State Anatomy Board 655 W. Baltimore Street  
Baltimore, MD 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

20 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pelvic fracture

osteoporosis

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

J. Adams MD

29c. License number

D32783

29d. Date signed (Month, Day, Year)

7/10/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph Adams MD 6565 N. Charles St. Suite 605; Towson, MD 21204

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

Benita B. Sparks

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22474

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                   |                                                        |                                                                                                                    |                                        |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|----------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1. Decedent's Name (First, Middle, Last)<br>ROBERT E. PRICE                                            |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                   | 2. Date of Death<br>Month Day Year<br>May 12 2000      |                                                                                                                    | 3. Time of Death<br>01:50 P.M.         |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4a. Facility Name (If not institution, give street and number)<br>Train Tracks under Route 50 Overpass |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                   | 4b. City, Town, or Location of Death<br>New Carrollton |                                                                                                                    | 4c. County of Death<br>Prince George's |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 5. Social Security Number<br>UNK                                                                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                            | 7. Age (In yrs. last birthday)<br>50 Yrs. | 8. Date of Birth (Month, Day, Year)<br>Nov 2, 1949                                                                                                                                                                                                                                                | 9. Birthplace (State or Foreign Country)<br>unk        |                                                                                                                    |                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Usual Residence of Decedent                                                                            |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                   |                                                        |                                                                                                                    |                                        |  |
| 10a. State<br>MD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        | 10b. County<br>Prince Georges                                                                                                                         |                                           | 10c. City, Town or Location<br>Landover                                                                                                                                                                                                                                                           |                                                        | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                     |                                        |  |
| 10e. Street and Number<br>6525 Old Landover Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                       |                                           | 10f. Zip Code<br>20785                                                                                                                                                                                                                                                                            |                                                        | 10g. Citizen of What Country?<br>USA                                                                               |                                        |  |
| 11. Marital Status<br>unk<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: unk |                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                      |                                                        | 14. Race - American Indian, Black, White, etc.<br>Specify: white                                                   |                                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) unk College (1-4 or 5+) unk                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        |                                                                                                                                                       |                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>unk                                                                                                                                                                                  |                                                        | 16b. Kind of Business/Industry<br>unk                                                                              |                                        |  |
| 17. Father's Name (First, Middle, Last)<br>unk                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                       |                                           | 18. Mother's Name (First, Middle, Maiden Surname)<br>unk                                                                                                                                                                                                                                          |                                                        |                                                                                                                    |                                        |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>O.C.M.E.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                        |                                                                                                                                                       |                                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>111 Penn Street Baltimore, MD 21201                                                                                                                                                              |                                                        |                                                                                                                    |                                        |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) in state                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                       |                                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Date                                                                                                                                                                                                                    |                                                        | 20c. Location - City or Town, State                                                                                |                                        |  |
| 21. Signature of Funeral Service Licensee<br>Ronald S. Wade, Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                       |                                           | 22. Name and Address of Facility<br>State Anatomy Board 655 W. Baltimore Street<br>Baltimore, MD 21201                                                                                                                                                                                            |                                                        |                                                                                                                    |                                        |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. MULTIPLE INJURIES<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |                                                                                                        |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                   |                                                        |                                                                                                                    |                                        |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                   |                                                        |                                                                                                                    |                                        |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                   |                                                        |                                                                                                                    |                                        |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                   |                                                        |                                                                                                                    |                                        |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                        |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                   |                                                        |                                                                                                                    |                                        |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                        |                                                                                                                                                       |                                           | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Scene |                                                        |                                                                                                                    |                                        |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                       |                                           | 28a. Date of Injury (Month, Day, Year)<br>5/12/00                                                                                                                                                                                                                                                 |                                                        | 28b. Time of Injury<br>10:45 A M                                                                                   |                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                       |                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                       |                                                        | 28d. Describe how injury occurred<br>Subject struck by train                                                       |                                        |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                        |                                                                                                                                                       |                                           | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>Railroad tracks                                                                                                                                                                                         |                                                        | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Rt. 50 Overpass New Carrollton, MD |                                        |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                   |                                                        |                                                                                                                    |                                        |  |
| 29b. Signature and title of certifier<br>J. Laron Locke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                       |                                           | 29c. License number<br>O.C.M.E.                                                                                                                                                                                                                                                                   |                                                        | 29d. Date signed (Month, Day, Year)<br>May 13, 2000                                                                |                                        |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                       |                                           |                                                                                                                                                                                                                                                                                                   |                                                        |                                                                                                                    |                                        |  |
| 31. Date filed (Month, Day, Year)<br>JUL 17 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                       |                                           | 32. Registrar's Signature<br>J. Laron Locke                                                                                                                                                                                                                                                       |                                                        |                                                                                                                    |                                        |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22475

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Charlene Lorraine Queen

2. Date of Death

Month Day Year  
July 12, 2000

3. Time of Death

1:55am

4a. Facility Name (If not institution, give street and number)

Villa of St. Michael Nursing Home

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

212-80-0194

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

40

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
01-18-60

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

2544 W. Lombard Street Unit F.

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Security Guard

16b. Kind of Business/Industry

Univ. of MD School

17. Father's Name (First, Middle, Last)

Charles Lewis

18. Mother's Name (First, Middle, Maiden Surname)

Rosetta Queen

19a. Informant's Name/Relationship (Type, Print)

Rosetta Code

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5601 Wesley Avenue Baltimore, Maryland

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Mem. Pk. Cem. 07-17-2000 Randallstown, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensing

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C.March FH 1101 E.North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Lymphoma: Central Nervous System 6 months  
Due to (or as a consequence of):  
b. Acquired Immodeficiency Syndrome 3 yrs.  
Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Weight Loss  
Decubitus ulcers

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural 5 ☐ Pending investigation  
☐ Accident 6 ☐ Could not be determined  
☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D23724

29d. Date signed (Month, Day, Year)

JULY 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OLUSEGUN LAWONIN, M.D. 3901 Greenspring Ave, Ste 301, Baltimore, MD 21211

31. Date filed (Month, Day, Year)

JUL 15 2000

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22476

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                   |                                                                                                                                                                                               |                                                             |                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>NIGEL ROBINSON</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                   | 2. Date of Death<br>Month Day Year<br><b>JULY 12 2000</b>                                                                                                                                     |                                                             | 3. Time of Death<br><b>10:56A</b>                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS HOSPITAL</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                   | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>                                                                                                                                 |                                                             | 4c. County of Death<br><b>NA</b>                                                                                                                                                                                                                                                            |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>213-55-9013</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        | 7. Age (In yrs. last birthday)<br>Yrs. <b>15</b>                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>04-13-99</b>      | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                   |                                                                                                                                                                                               |                                                             |                                                                                                                                                                                                                                                                                             |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 10b. County<br><b>NA</b>                                                                                                                          | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                               |                                                             | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>2517 Linden Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   | 10f. Zip Code<br><b>21217</b>                                                                                                                                                                 |                                                             | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Infant</b> College (14 or 5+) <b>Infant</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Infant</b>                                                                    |                                                             | 16b. Kind of Business/Industry<br><b>Infant</b>                                                                                                                                                                                                                                             |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                             | 17. Father's Name (First, Middle, Last)<br><b>Unknown</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>China Robinson</b>                                                                                                                    |                                                             |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kira Sekulow</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7911 Tilmont Avenue Baltimore, MD. 21234</b>                                              |                                                             |                                                                                                                                                                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery 07-17-2000 Baltimore, MD</b>                                                                   |                                                             | 20c. Location - City or Town, State                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                   | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202<br/>WM.C.March FH 1101 E. North Avenue</b>                                                                                   |                                                             |                                                                                                                                                                                                                                                                                             |
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>HYPOXIA</b><br>Due to (or as a consequence of):<br><b>PNEUMOTHORAX</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>PULMONARY HYPERTENSION</b><br><b>OBSTRUCTIVE SLEEP APNEA + HEART DISEASE</b> |                                                                                                                                                   |                                                                                                                                                                                               |                                                             | Approximate Interval Between Onset and Death<br><b>Days 2 hr months months</b>                                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>TRACHEITIS</b><br><b>POSSIBLE PNEUMONITIS</b><br><b>BRONCHOMALACIA</b>                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                   |                                                                                                                                                                                               |                                                             | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                            |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                   |                                                                                                                                                                                               |                                                             | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                   | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                        | 28b. Time of Injury<br><b>M</b>                             | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                 |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 28d. Describe how injury occurred                                                                                                                 |                                                                                                                                                                                               |                                                             |                                                                                                                                                                                                                                                                                             |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                   |                                                                                                                                                                                               |                                                             |                                                                                                                                                                                                                                                                                             |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                   |                                                                                                                                                                                               |                                                             |                                                                                                                                                                                                                                                                                             |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 29c. License number<br><b>RES-000</b>                                                                                                             |                                                                                                                                                                                               | 29d. Date signed (Month, Day, Year)<br><b>JULY 12, 2000</b> |                                                                                                                                                                                                                                                                                             |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JOSEPHINE LOK 600 N. WOLFE ST., BALTIMORE, MD 21287</b>                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                   |                                                                                                                                                                                               |                                                             |                                                                                                                                                                                                                                                                                             |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                           | 31. Date filed (Month, Day, Year)<br><b>JUL 15 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                   | 32. Registrar's Signature<br>                                                                                                                                                                 |                                                             |                                                                                                                                                                                                                                                                                             |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22477

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN WILLIAM SMITH, SR

2. Date of Death

Month

Day

Year

3. Time of Death

0951

4a. Facility Name (If not institution, give street and number)

ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCHESTER

Funeral  
Director

5. Social Security Number

216-28-5176

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

4-28-1932

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

WORCHESTER

10c. City, Town or Location

OCEAN CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

117 CHANNEL BUOY ROAD

10f. Zip Code

21842

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9<sup>th</sup>

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

SALES

16b. Kind of Business/Industry

FOOD

17. Father's Name (First, Middle, Last)

HOWARD M. SMITH

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE A. BROWN

19a. Informant's Name/Relationship (Type, Print)

THERESA SMITH

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

117 CHANNEL BUOY ROAD / OCEAN CITY, MARYLAND 21842

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARDENS OF FAITH CEMETERY 7/15/00 BALTIMORE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

ROBERT C. ALTENBURG

22. Name and Address of Facility

ALTENBURG FUNERAL HOME, P.A.

6009 HARRARD RD. BALTIMORE, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

N-J

29c. License number

H44283

29d. Date signed (Month, Day, Year)

7/12/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Durlak

9733 Heilmann Drive

Berlin MD

31. Date filed (Month, Day, Year) - -

JUL 17 2000

32. Registrar's Signature

Blanca A. Spotts

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, 7

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DOB 04/28/1932

216-28-5176

John Smith

7/12/00

1290

WESTER

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WESTER

WESTER

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State of Maryland / Department of Health and Mental Hygiene 00 22478

## Certificate of Death

Reg. No.

|                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                      |                                                                  |                                                                                                                                             |  |
|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Milton Jacob Schott                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  | 2. Date of Death<br>Month Day Year<br>07 14 2000                                                                                                                                                                                                                                                                |  |                                                                                      |                                                                  | 3. Time of Death<br>1:30 am                                                                                                                 |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br>Hospice of Baltimore Gilchrist Center                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                       |  | 4b. City, Town, or Location of Death<br>Towson                                                                                                                                                                                                                                                                  |  |                                                                                      |                                                                  | 4c. County of Death<br>Baltimore                                                                                                            |  |
| Funeral<br>Director                 | 5. Social Security Number<br>215-09-7013                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                        |  | 7. Age (In yrs. last birthday)<br>89 Yrs.                                                                                                                                                                                                                                                                       |  | 8. Date of Birth (Month, Day, Year)<br>10/27/1910                                    |                                                                  | 9. Birthplace (State or Foreign Country)<br>Maryland                                                                                        |  |
|                                     | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                      |                                                                  |                                                                                                                                             |  |
| To Be Completed by Funeral Director | 10a. State<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 10b. County<br>Baltimore                                                                                                                              |  | 10c. City, Town or Location<br>Lutherville                                                                                                                                                                                                                                                                      |  |                                                                                      |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                     |  |
|                                     | 10e. Street and Number<br>313 Felton Road                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |  | 10f. Zip Code<br>21093                                                                                                                                                                                                                                                                                          |  | 10g. Citizen of What Country?<br>USA                                                 |                                                                  |                                                                                                                                             |  |
|                                     | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                             |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:                                                                                                                |  |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: white |                                                                                                                                             |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Transportation Supervisor                                                                                                                                                                          |  |                                                                                      | 16b. Kind of Business/Industry<br>Metal products                 |                                                                                                                                             |  |
|                                     | 17. Father's Name (First, Middle, Last)<br>John Schott                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sophia Lohrmann                                                                                                                                                                                                                                            |  |                                                                                      |                                                                  |                                                                                                                                             |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br>Robert J. Schott / son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                       |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9 Weston Court; Lutherville, MD 21093                                                                                                                                                                          |  |                                                                                      |                                                                  |                                                                                                                                             |  |
|                                     | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                    |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gardens<br>Dulaney Valley Memorial                                          |  | 20c. Date<br>7/17/00                                                                                                                                                                                                                                                                                            |  | 20d. Location - City or Town, State<br>Timonium, MD                                  |                                                                  |                                                                                                                                             |  |
|                                     | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                                                                                                                       |  | 22. Name and Address of Facility<br>Ruck Towson Funeral Home Inc. 1050 York Rd. Towson, MD 21204                                                                                                                                                                                                                |  |                                                                                      |                                                                  |                                                                                                                                             |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. obstructive lung disease<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                      |                                                                  |                                                                                                                                             |  |
|                                     | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>probable lung cancer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                      |                                                                  |                                                                                                                                             |  |
| Physician<br>/Medical<br>Examiner   | 23c. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                       |  |                                                                                      |                                                                  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                       |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice |  |                                                                                      |                                                                  |                                                                                                                                             |  |
|                                     | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                             |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                |  | 28b. Time of Injury<br>M                                                                                                                                                                                                                                                                                        |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                                                           |  |
|                                     | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                                                                                                                       |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                    |  |                                                                                      |                                                                  |                                                                                                                                             |  |
|                                     | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                          |  |                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                      |                                                                  |                                                                                                                                             |  |
| State<br>Registrar                  | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                       |  | 29c. License number<br>D25205                                                                                                                                                                                                                                                                                   |  | 29d. Date signed (Month, Day, Year)<br>July 14, 2000                                 |                                                                  |                                                                                                                                             |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>W.A. Riley G.B.M.C. 6781 N. Charles St, Balto. md 21208                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                      |                                                                  |                                                                                                                                             |  |
|                                     | 31. Date filed (Month, Day, Year)<br>JUL 17 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                       |  | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                   |  |                                                                                      |                                                                  |                                                                                                                                             |  |



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State of Maryland / Department of Health and Mental Hygiene 00 22479

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

KAYLA MONET SCROGGINS

2. Date of Death

MARCH 29 2000

3. Time of Death

18:00

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

N/A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

3-28-00

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5006 Goodnow Road Apt. 5

10f. Zip Code

21206

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

N/A

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Stacy Cottman

19a. Informant's Name/Relationship (Type, Print)

Stacy Cottman / mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5006 Goodman Rd Apt. 5 - Balto. Md. 21206

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) Disposal

20b. Place of Disposition (Name of cemetery, crematory or other place)

Johns Hopkins Hospital

Date

3/30/00

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

Reborah Evans

22. Name and Address of Facility

SHH-600 N. Wolfe St- 21287

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

EXTREME PREMATUREITY

Approximate Interval Between Onset and Death

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

COMPLEX CYANOTIC HEART DISEASE 2 DAYS

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RESPIRATORY DISTRESS SYNDROME

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Edward E. Lawson MD

29c. License number

D0054309

29d. Date signed (Month, Day, Year)

MARCH 29, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDWARD E. LAWSON MD 600 N. Wolfe St Baltimore MD 21287

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 15 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



CHURCH OF THE

UNITED METHODIST CHURCH

1000 10th Street, N.W. Washington, D.C. 20004

Page 2

United Methodist Church

1000 10th Street, N.W. Washington, D.C. 20004

United Methodist Church

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22480

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                   |                                                     |                                                                                                                                                                                                          |                                  |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1. Decedent's Name (First, Middle, Last)<br>AUDREY COSTA SANFORD                                        |                                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                   | 2. Date of Death<br>Month Day Year<br>July 13, 2000 |                                                                                                                                                                                                          | 3. Time of Death<br>9:50 AM      |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4a. Facility Name (If not institution, give street and number)<br>Hospice of Baltimore Gilchrist Center |                                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                   | 4b. City, Town, or Location of Death<br>Baltimore   |                                                                                                                                                                                                          | 4c. County of Death<br>Baltimore |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 5. Social Security Number<br>216-28-5041                                                                | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br>69 Yrs. | 8. Date of Birth (Month, Day, Year)<br>June 12, 1931                                                                                                                                              | 9. Birthplace (State or Foreign Country)<br>Md.     |                                                                                                                                                                                                          |                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Usual Residence of Decedent                                                                             |                                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                   |                                                     |                                                                                                                                                                                                          |                                  |  |
| 10a. State<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         | 10b. County<br>Harford                                                                                                                                                                                                                                                                                          |                                           | 10c. City, Town or Location<br>Bel Air                                                                                                                                                            |                                                     | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |                                  |  |
| 10e. Street and Number<br>724 Heston Lane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           | 10f. Zip Code<br>21014                                                                                                                                                                            |                                                     | 10g. Citizen of What Country?<br>USA                                                                                                                                                                     |                                  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                           |                                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary                                                                            |                                                     | 16b. Kind of Business/Industry<br>Legal                                                                                                                                                                  |                                  |  |
| 17. Father's Name (First, Middle, Last)<br>Charles Costa                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           | 18. Mother's Name (First, Middle, Maiden Surname)<br>Annabelle Schoelkoph                                                                                                                         |                                                     |                                                                                                                                                                                                          |                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Mr. Gordon A. Sanford, Jr./son                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>PO Box 1521 Freemont, Ca. 94538                                                                  |                                                     |                                                                                                                                                                                                          |                                  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dulaney Valley Memorial                                                                                                                                                                                                               |                                           | 20c. Date<br>7/17/00                                                                                                                                                                              |                                                     | 20d. Location - City or Town, State<br>Timonium, Md.                                                                                                                                                     |                                  |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204                                                                                             |                                                     |                                                                                                                                                                                                          |                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Colon cancer<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                   |                                                     |                                                                                                                                                                                                          |                                  |  |
| Approximate Interval Between Onset and Death<br>5 years                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                   |                                                     |                                                                                                                                                                                                          |                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                   |                                                     | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                   |                                                     | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                |                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                   |                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                              |                                  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice |                                           |                                                                                                                                                                                                   |                                                     |                                                                                                                                                                                                          |                                  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                           |                                           | 28b. Time of Injury<br>M                                                                                                                                                                          |                                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                     |                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                          |                                           | 28d. Describe how injury occurred                                                                                                                                                                 |                                                     |                                                                                                                                                                                                          |                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                    |                                           |                                                                                                                                                                                                   |                                                     |                                                                                                                                                                                                          |                                  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                              |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                   |                                                     |                                                                                                                                                                                                          |                                  |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           | 29c. License number<br>D25205                                                                                                                                                                     |                                                     | 29d. Date signed (Month, Day, Year)<br>July 13, 2000                                                                                                                                                     |                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>W.A. Riley GBMC 6701 N. Charles St. Balto. md 2120x                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           |                                                                                                                                                                                                   |                                                     |                                                                                                                                                                                                          |                                  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 13 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |                                                                                                                                                                                                                                                                                                                 |                                           | 32. Registrar's Signature<br>                                                                                                                                                                     |                                                     |                                                                                                                                                                                                          |                                  |  |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene 00 22481

Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                     |                                                     |                          |                                                   |                                                                                                                                                                                                  |                                                 |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|--------------------------|---------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Joseph G. Schaffner                                         |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                     | 2. Date of Death<br>Month Day Year<br>July 13, 2000 |                          |                                                   |                                                                                                                                                                                                  | 3. Time of Death<br>7:30 AM                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>Hospice of Baltimore Gilchrist Center |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                     | 4b. City, Town, or Location of Death<br>Towson      |                          |                                                   |                                                                                                                                                                                                  | 4c. County of Death<br>Baltimore                |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>219-01-0628                                                                |                                                                                                                                                   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                                     | 7. Age (In yrs. last birthday)<br>81 Yrs.           |                          | 8. Date of Birth (Month, Day, Year)<br>11/27/1918 |                                                                                                                                                                                                  | 9. Birthplace (State or Foreign Country)<br>MD. |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                             |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                     |                                                     |                          |                                                   |                                                                                                                                                                                                  |                                                 |  |
| 10a. State<br>MD.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         | 10b. County<br>Baltimore                                                                                                                          |                                                                            | 10c. City, Town or Location<br>Timonium                                                                                                                                                                                                                                                             |                                                     |                          |                                                   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                   |                                                 |  |
| 10e. Street and Number<br>41 Gorsuch Rd.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                                                                                                                   |                                                                            | 10f. Zip Code<br>21093                                                                                                                                                                                                                                                                              |                                                     |                          |                                                   | 10g. Citizen of What Country?<br>USA                                                                                                                                                             |                                                 |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                        |                                                     |                          |                                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: USA                                                                                                                                   |                                                 |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                                                                                                                   |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Engineer                                                                                                                                                                               |                                                     |                          |                                                   | 16b. Kind of Business/Industry<br>Chemical                                                                                                                                                       |                                                 |  |
| 17. Father's Name (First, Middle, Last)<br>Lewis A. Schaffner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                                                                                                                   |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br>Carrie Stielper                                                                                                                                                                                                                                |                                                     |                          |                                                   |                                                                                                                                                                                                  |                                                 |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Judith Ulrich (daughter)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                         |                                                                                                                                                   |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11971 Harford Rd. Glen Arm, MD. 21057                                                                                                                                                              |                                                     |                          |                                                   |                                                                                                                                                                                                  |                                                 |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |                                                                                                                                                   |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Dulaney Valley Memorial Grdns.                                                                                                                                                                                            |                                                     |                          |                                                   | 20c. Location - City or Town, State<br>07/17/2000 Timonium, MD.                                                                                                                                  |                                                 |  |
| 21. Signature of Funeral Service Licensee<br>Dennis C. Carroll                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         |                                                                                                                                                   |                                                                            | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, MD. 21204                                                                                                                                                                                               |                                                     |                          |                                                   |                                                                                                                                                                                                  |                                                 |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Lung Cancer<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Approximate Interval Between Onset and Death<br>4 months |                                                                                                         |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                     |                                                     |                          |                                                   |                                                                                                                                                                                                  |                                                 |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                     |                                                     |                          |                                                   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                     |                                                     |                          |                                                   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                     |                                                     |                          |                                                   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                 |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         |                                                                                                                                                   |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Hospice |                                                     |                          |                                                   |                                                                                                                                                                                                  |                                                 |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |                                                                                                                                                   |                                                                            | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                               |                                                     | 28b. Time of Injury<br>M |                                                   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                 |                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                                                                                                                                                   |                                                                            | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                   |                                                     |                          |                                                   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                           |                                                 |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                                                                                                                                                   |                                                                            | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                        |                                                     |                          |                                                   |                                                                                                                                                                                                  |                                                 |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                                                                     |                                                                                                         |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                     |                                                     |                          |                                                   |                                                                                                                                                                                                  |                                                 |  |
| 29b. Signature and Title of Certifier<br>Anthony Riley                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                                                                                                                   |                                                                            | 29c. License number<br>D25205                                                                                                                                                                                                                                                                       |                                                     |                          |                                                   | 29d. Date signed (Month, Day, Year)<br>July 13, 2000                                                                                                                                             |                                                 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>W.A. Riley G.B.M.C. 6701 N. Charles St. Balto. ind 2120x                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |                                                                                                                                                   |                                                                            |                                                                                                                                                                                                                                                                                                     |                                                     |                          |                                                   |                                                                                                                                                                                                  |                                                 |  |
| 31. Date filed (Month, Day, Year)<br>JUL 15 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |                                                                                                                                                   |                                                                            | 32. Registrar's Signature<br>Bent                                                                                                                                                                                                                                                                   |                                                     |                          |                                                   |                                                                                                                                                                                                  |                                                 |  |




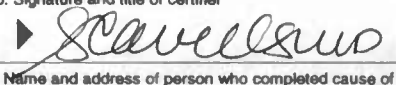
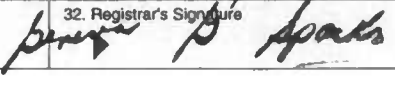
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22482

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|-------------------------------|--------------------------------------------------------------------|----|---------------------------------|----|--------------------------|----|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>OSCAR L. SMITH</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         | 2. Date of Death<br>Month <b>07</b> Day <b>12</b> Year <b>2000</b>                                                                                                                            |                                                                                                                                                                                                  | 3. Time of Death<br><b>0620</b>                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>BALTIMORE V.A. MEDICAL CENTER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>                                                                                                                                      |                                                                                                                                                                                                  | 4c. County of Death<br><b>NA</b>                                        |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>219-58-0381</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                        |                                         | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs.                                                                                                                                              |                                                                                                                                                                                                  | 8. Date of Birth (Month, Day, Year)<br><b>10-15-52</b>                  |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>DC</b>                                                                                             |                                         | 10. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                 |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                          | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                             | 10b. County<br><b>NA</b>                                                                                                                          |                                         | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 10e. Street and Number<br><b>611 North Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         | 10f. Zip Code<br><b>Baltimore</b>                                                                                                                                                             |                                                                                                                                                                                                  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                         | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                                                                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th Grade</b><br>College (1-4 or 5+) <b>NA</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                             | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>                       |                                         | 16b. Kind of Business/Industry<br><b>various trades</b>                                                                                                                                       |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 17. Father's Name (First, Middle, Last)<br><b>Henry C. Smith</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Smith</b>                                                                                                                       |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 19a. Informant's Name/Relationship (Type, Print)<br><b>Helen Smith</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21212<br/>403 E. Northern Parkway Baltimore, Maryland</b>                                 |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest VA Cem.</b>                                          |                                         | 20c. Location - City or Town, State<br><b>MD.</b>                                                                                                                                             |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202<br/>WM. C. March FH 1101 E. North Avenue</b>                                     |                                         |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>HEPATIC ENCEPHALOPATHY</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <b>3 WEEKS</b> </td> </tr> <tr> <td>b.</td> <td><b>HEPATOCELLULAR CARCINOMA</b></td> </tr> <tr> <td>c.</td> <td><b>HEPATITIS C VIRUS</b></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>HEPATIC ENCEPHALOPATHY</b> | Approximate Interval Between Onset and Death<br><br><b>3 WEEKS</b> | b. | <b>HEPATOCELLULAR CARCINOMA</b> | c. | <b>HEPATITIS C VIRUS</b> | d. |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                                                                                                                                                                            | a.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>HEPATIC ENCEPHALOPATHY</b>                                                                                                                                                                                                                                                               | Approximate Interval Between Onset and Death<br><br><b>3 WEEKS</b>                                                                                |                                         |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | b.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>HEPATOCELLULAR CARCINOMA</b>                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | c.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>HEPATITIS C VIRUS</b>                                                                                                                                                                                                                                                                    |                                                                                                                                                   |                                         |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | d.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         |                                                                                                                                                                                               | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         |                                                                                                                                                                                               | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         |                                                                                                                                                                                               | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                          |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                         |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>         |                                                                                                                                                                                               | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                 |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                                                                                                   |                                         |                                                                                                                                                                                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   | 29c. License number<br><b>D 0054734</b> |                                                                                                                                                                                               | 29d. Date signed (Month, Day, Year)<br><b>07 12 2000</b>                                                                                                                                         |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ERICA M. SCAVELLA, M.D., VAMHCS, 10 N. GREENE ST., BALTIMORE, MD</b>                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                             |                                                                                                                                                   |                                         |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |
| 31. Date filed (Month, Day, Year)<br><b>JUL 15 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 32. Registrar's Signature<br>                                                                                                                                                                            |                                                                                                                                                   |                                         |                                                                                                                                                                                               |                                                                                                                                                                                                  |                                                                         |  |                                                                                                                                                                                                                                   |    |                               |                                                                    |    |                                 |    |                          |    |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

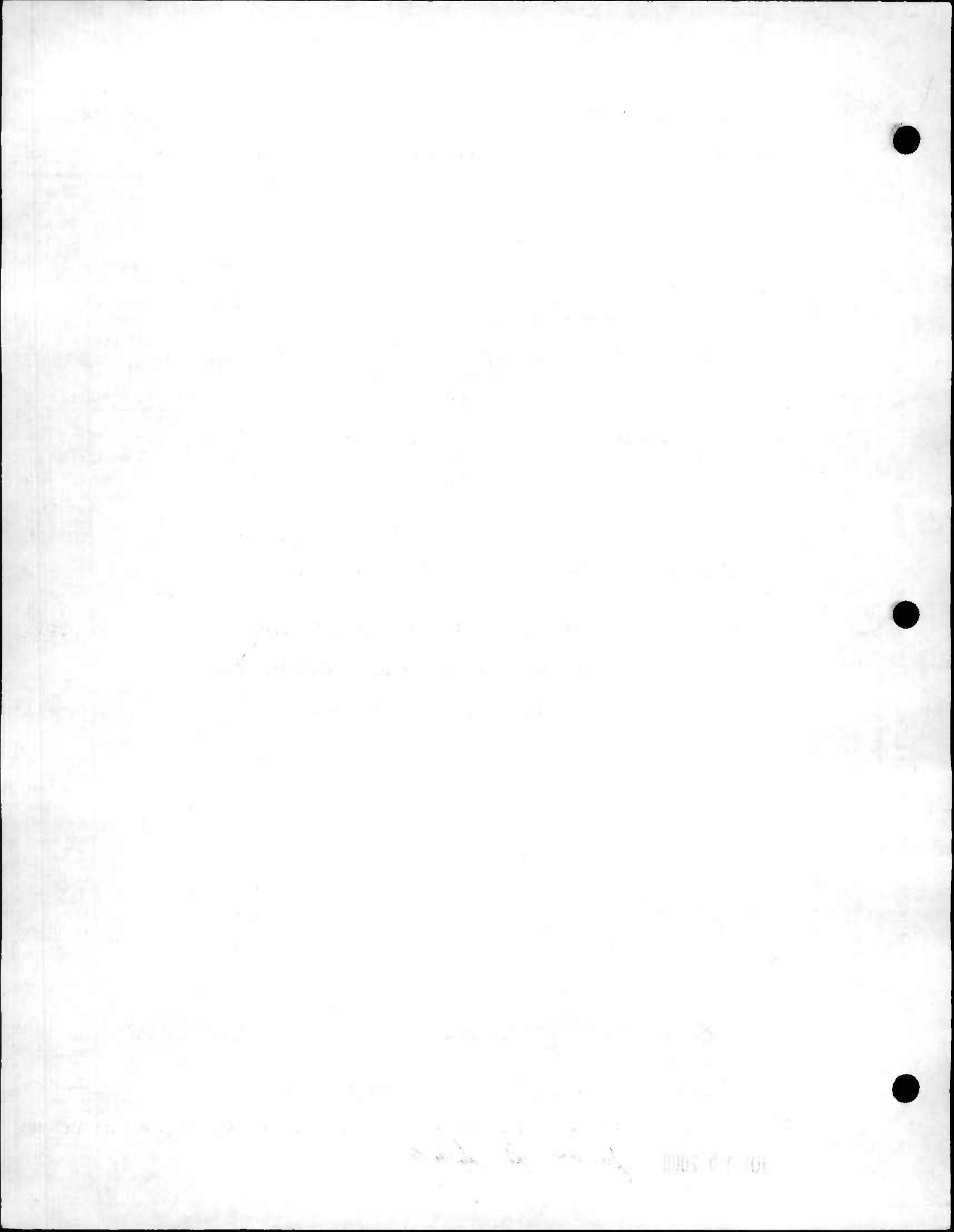
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22483

amended item 20b per fh g785 7/17/00 ah

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                           |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                              |                        |                                                                                  |                                                                                                |                                                       |                                              |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|---------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|----------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Tucker</b>                              |                           |                                                                                                                                                   |                                                                                                                                     | 2. Date of Death<br>Month <b>7</b> Day <b>8</b> Year <b>2000</b>                                                                                                                             |                        |                                                                                  |                                                                                                | 3. Time of Death<br><b>11:20 p.m.</b>                 |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not Institution, give street and number)<br><b>2503 Violet Avenue</b> |                           |                                                                                                                                                   |                                                                                                                                     | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                                                                     |                        |                                                                                  |                                                                                                | 4c. County of Death                                   |                                              |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br><b>220-22-7730</b>                                             |                           | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |                                                                                                                                     | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.                                                                                                                                             |                        | 8. Date of Birth (Month, Day, Year)<br><b>10-8-1926</b>                          |                                                                                                | 9. Birthplace (State or Foreign Country)<br><b>VA</b> |                                              |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                 |                           |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                              |                        |                                                                                  |                                                                                                |                                                       |                                              |  |
| 10a. State<br><b>Md</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             | 10b. County<br><b>N/A</b> |                                                                                                                                                   | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                     |                                                                                                                                                                                              |                        |                                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |                                                       |                                              |  |
| 10e. Street and Number<br><b>2503 Violet Avenue</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                             |                           |                                                                                                                                                   | 10f. Zip Code<br><b>21215</b>                                                                                                       |                                                                                                                                                                                              |                        |                                                                                  | 10g. Citizen of What Country?<br><b>U S A</b>                                                  |                                                       |                                              |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                |                                                                                             |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                                                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                        |                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |                                                       |                                              |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th grade</b><br>College (1-4 or 5+) <b>N/A</b>                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                           |                                                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic Worker</b> |                                                                                                                                                                                              |                        |                                                                                  | 16b. Kind of Business/Industry<br><b>Private Homes</b>                                         |                                                       |                                              |  |
| 17. Father's Name (First, Middle, Last)<br><b>Schofield West</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                             |                           |                                                                                                                                                   |                                                                                                                                     | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Sterling Coleman</b>                                                                                                                 |                        |                                                                                  |                                                                                                |                                                       |                                              |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara Wilkerson- Granddaughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                             |                           |                                                                                                                                                   |                                                                                                                                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6514 Park Heights Avenue Apt B Baltimore, Md</b>                                         |                        |                                                                                  |                                                                                                |                                                       |                                              |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                         |                                                                                             |                           | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arbutus Memorial Park</b>                                            |                                                                                                                                     |                                                                                                                                                                                              | Date<br><b>7/18/00</b> |                                                                                  | 20c. Location - City or Town, State<br><b>Arbutus, Md</b>                                      |                                                       |                                              |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                             |                           |                                                                                                                                                   |                                                                                                                                     | 22. Name and Address of Facility<br><b>March F/H West<br/>4300 Wabash Ave., Baltimore, Md. 21215</b>                                                                                         |                        |                                                                                  |                                                                                                |                                                       |                                              |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Coronary Artery Disease</b><br>Due to (or as a consequence of):<br><b>b. Chronic Renal Failure</b><br>Due to (or as a consequence of):<br><b>c. Cardiac Arrest</b><br>Due to (or as a consequence of):<br><b>d. Atherosclerosis</b> |                                                                                             |                           |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                              |                        |                                                                                  |                                                                                                |                                                       | Approximate Interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Status Post Coronary Bypass Surgery</b>                                                                                                                                                                                                                                                                                                                                                          |                                                                                             |                           |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                              |                        |                                                                                  |                                                                                                |                                                       |                                              |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                              |                                                                                             |                           |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                              |                        |                                                                                  |                                                                                                |                                                       |                                              |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                             |                           |                                                                                                                                                   |                                                                                                                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                           |                        |                                                                                  |                                                                                                |                                                       |                                              |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                             |                           |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                              |                        |                                                                                  |                                                                                                |                                                       |                                              |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                   |                                                                                             |                           |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                              |                        |                                                                                  |                                                                                                |                                                       |                                              |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                    |                                                                                             |                           | 28a. Date of Injury (Month, Day Year)                                                                                                             |                                                                                                                                     | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                        | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                | 28d. Describe how injury occurred                     |                                              |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                             |                           |                                                                                                                                                   |                                                                                                                                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                 |                        |                                                                                  |                                                                                                |                                                       |                                              |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                  |                                                                                             |                           |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                              |                        |                                                                                  |                                                                                                |                                                       |                                              |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                             |                           |                                                                                                                                                   |                                                                                                                                     | 29c. License number<br><b>D17635</b>                                                                                                                                                         |                        | 29d. Date signed (Month, Day, Year)<br><b>7/11/00</b>                            |                                                                                                |                                                       |                                              |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Luis A. Mispireta 201 E. University Pkwy., Baltimore, Md. 21218</b>                                                                                                                                                                                                                                                                                                                                                                |                                                                                             |                           |                                                                                                                                                   |                                                                                                                                     |                                                                                                                                                                                              |                        |                                                                                  |                                                                                                |                                                       |                                              |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                             |                           | 32. Registrar's Signature<br>                                 |                                                                                                                                     |                                                                                                                                                                                              |                        |                                                                                  |                                                                                                |                                                       |                                              |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22484

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph John Thorn, III

2. Date of Death

Month  
JulyDay  
12Year  
2000

3. Time of Death

15:01

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

213-40-1230

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

May 29, 1941

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7026 Fieldcrest Road

10f. Zip Code

21215

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

-0-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sunpaper Carrier

16b. Kind of Business/Industry

Baltimore Sunpaper

17. Father's Name (First, Middle, Last)

Joseph John Thorn, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Matilda Smith

19a. Informant's Name/Relationship (Type, Print)

Patricia A. Lohinski - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6566 McBeth Way; Sykesville, Maryland 21784

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

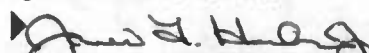
Date

7/15/2000

20c. Location - City or Town, State

Woodlawn, Maryland

21. Signature of Funeral Service Licensee

 M00869

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.  
8728 Liberty Road; Randallstown, Maryland 21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

Peripheral vascular disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

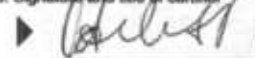
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

 resident physician  
Adelaida Ortiz

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

July 12, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

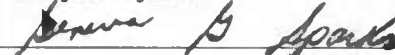
Adelaida Ortiz, 2401 W. Belvedere Ave, Baltimore, Md. 21215

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature



ORIGINAL

Patient Known As: Joseph Thorn  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Eddie Tapp, Jr. amend item 20b,c per State of Maryland Department of Health and Mental Hygiene

00 22485

AMEND ITEMS: #23 PART I, II, 27 PER MEO G 785 7-26-00 WR Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                            |                                                                                                  |                                                                                                                                                                                                                                       |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                           |                                                                                                                                                                                                  |                                |                                                                                                                                                                                                                                                                                                             |                                                 |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                          | 1. Decedent's Name (First, Middle, Last)<br><b>Eddie Tapp, Jr.</b>                               |                                                                                                                                                                                                                                       |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 2. Date of Death<br>Month Day Year<br><b>July 03 2000</b> |                                                                                                                                                                                                  |                                |                                                                                                                                                                                                                                                                                                             | 3. Time of Death<br><b>11:39 P.M.</b>           |  |
|                                                                                                                                                                                                                                                                            | 4a. Facility Name (If not institution, give street and number)<br><b>Union Memorial Hospital</b> |                                                                                                                                                                                                                                       |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |                                                                                                                                                                                                  |                                |                                                                                                                                                                                                                                                                                                             | 4c. County of Death<br><b>N/A</b>               |  |
| Funeral<br>Director                                                                                                                                                                                                                                                        | 5. Social Security Number<br><b>241-50-8526</b>                                                  |                                                                                                                                                                                                                                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br><b>64</b> Yrs.          |                                                                                                                                                                                                  | If Under 1 Year<br>Months Days |                                                                                                                                                                                                                                                                                                             | If Under 24 Hrs.<br>Hours Min.                  |  |
|                                                                                                                                                                                                                                                                            | 8. Date of Birth (Month, Day, Year)<br><b>11-05-35</b>                                           |                                                                                                                                                                                                                                       | 9. Birthplace (State or Foreign Country)<br><b>NC</b>                      |                                                                                                                                                                                                                                                                                                                                                                                                                              | 10a. State<br><b>MD</b>                                   |                                                                                                                                                                                                  | 10b. County<br><b>NA</b>       |                                                                                                                                                                                                                                                                                                             | 10c. City, Town or Location<br><b>Baltimore</b> |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                |                                                                                                  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                        |                                                                            | 10e. Street and Number<br><b>1725 Chilton Street</b>                                                                                                                                                                                                                                                                                                                                                                         |                                                           | 10f. Zip Code<br><b>21218</b>                                                                                                                                                                    |                                | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                                                                                                                                 |                                                 |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                             |                                                                                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                     |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                                                                                                                                                                 |                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                          |                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th Grade</b><br>College (1-4 or 5+) <b>NA</b>                                                                                                                                                            |                                                 |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cement Mason</b>                                                                                                                                           |                                                                                                  | 16b. Kind of Business/Industry<br><b>J.H.U.P.L.</b>                                                                                                                                                                                   |                                                                            | 17. Father's Name (First, Middle, Last)<br><b>Eddie Tapp, Sr.</b>                                                                                                                                                                                                                                                                                                                                                            |                                                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Caroline Chavis</b>                                                                                                                      |                                | 19a. Informant's Name/Relationship (Type, Print)<br><b>Dora M. Tapp</b>                                                                                                                                                                                                                                     |                                                 |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1725 Chilton Avenue Baltimore, Maryland 21218</b>                                                                                                                      |                                                                                                  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>                                                                                                                                                                                                                                                                                                                         |                                                           | 20c. Location - City or Town, State<br><b>Anne Arundel Co. Maryland</b>                                                                                                                          |                                | 20d. Date<br><b>07-10-2000</b>                                                                                                                                                                                                                                                                              |                                                 |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                            |                                                                                                  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202</b><br><b>WM.C.March FH 1101 E. North Avenue</b>                                                                                                                     |                                                                            | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br><b>COMPLICATED BY GASTROINTESTINAL BLEEDING</b>                                                                                                   |                                                           | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                | 23c. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                       |                                                 |  |
| 23d. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                         |                                                                                                  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                 |                                                                            | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                           |                                                           | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                |                                | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>at scene</b> |                                                 |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |                                                                                                  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                 |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                                                                                                                                                                                                                                                              |                                                           | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |                                | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                           |                                                 |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                     |                                                                                                  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                          |                                                                            | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                           | 29b. Signature and title of certifier<br>                                                                     |                                | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                                      |                                                 |  |
| 29d. Date signed (Month, Day, Year)<br><b>July 14, 2000</b>                                                                                                                                                                                                                |                                                                                                  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>David Fowler, M.D. for Stephen Radentz, M.D.</b>                                                                                           |                                                                            | 31. Date filed (Month, Day, Year)<br><b>JUL 15 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                           | 32. Registrar's Signature<br>                                                                                 |                                | 33. State Registrar<br><b>State</b>                                                                                                                                                                                                                                                                         |                                                 |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22486

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PHILIP FRANKLIN WAGLEY

2. Date of Death

Month Day Year  
July 13, 2000

3. Time of Death

7:45 P.M.

4a. Facility Name (If not institution, give street and number)

21 Meadow Road

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

094-20-8795

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 5, 1917

9. Birthplace (State or Foreign Country)

Texas

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

21 Meadow Road

10f. Zip Code

21212

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1954-56

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+ years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Physician

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Evritt Franklin Wagley

18. Mother's Name (First, Middle, Maiden Summa)

Louise Paxton

19a. Informant's Name/Relationship (Type, Print)

Mary Frances Wagley (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21 Meadow Road Baltimore, Maryland 21212

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

7-15-2000

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

George A. Fenwick

22. Name and Address of Facility

Mitchell-Wiedefeld Funeral Home, Inc.  
6500 York Road Baltimore, Maryland 21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MULTIPLE MYELOMA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ATRIAL FIBRILLATION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daniel C. Sapir M.D.

29c. License number

D10670

29d. Date signed (Month, Day, Year)

7/14/00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Sapir, M.D. 10755 Falls Road Baltimore, Maryland

31. Date filed (Month, Day, Year)

JUL 17 2000

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar




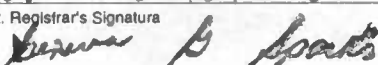
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22487

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                         |                                                                                                     |                                                                                                                                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>Venerable D. Wilson</b>                                                                                                                                                                |                                                                                                                                                                                                                                                                                             | 2. Date of Death<br>Month <b>July</b> Day <b>12</b> Year <b>2000</b>                                                                                    |                                                                                                     | 3. Time of Death<br><b>12:38 AM</b>                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital</b>                                                                                                                                               |                                                                                                                                                                                                                                                                                             | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                                                                                                |                                                                                                     | 4c. County of Death<br><b>N/A</b>                                                                                                                                                            |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>220-03-0414</b>                                                                                                                                                                                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.                                                                                                        | If Under 1 Year<br>Months Days                                                                      | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 8. Date of Birth (Month, Day, Year)<br><b>10-22-1918</b>                                                                                                                                                                              |                                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>Va</b>                                                                                                   |                                                                                                     |                                                                                                                                                                                              |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Usual Residence of Decedent                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                             |                                                                                                                                                         |                                                                                                     |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br><b>Md</b>                                                                                                                                                                                                               | 10b. County<br><b>N/A</b>                                                                                                                                                                                                                                                                   | 10c. City, Town or Location<br><b>Baltimore</b>                                                                                                         |                                                                                                     | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>2205 Wheatley Drive</b>                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                             | 10f. Zip Code<br><b>21207</b>                                                                                                                           |                                                                                                     | 10g. Citizen of What Country?<br><b>U S A</b>                                                                                                                                                |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                        |                                                                                                                                                                                                                                                                                             | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:       |                                                                                                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                                                                                                                                               |                                                                                                                                                                                                                                                                                             | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th grade</b><br>College (1-4 or 5+) <b>N/A</b>      |                                                                                                     |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sky Cap</b>                                                                                                           |                                                                                                                                                                                                                                                                                             | 16b. Kind of Business/Industry<br><b>Ragan Airport</b>                                                                                                  |                                                                                                     |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. Father's Name (First, Middle, Last)<br><b>Robert Wilson</b>                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Esther Belle</b>                                                                                |                                                                                                     |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Inell Dorothy Wilson- Wife</b>                                                                                                                                                 |                                                                                                                                                                                                                                                                                             | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2205 Wheatley Drive Apt 201 Baltimore, Md 21207</b> |                                                                                                     |                                                                                                                                                                                              |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |                                                                                                                                                                                                                                                                                             | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crownsville Veteran Cem</b>                                                |                                                                                                     | 20c. Location - City or Town, State<br><b>7-17-00 Crownsville, Md</b>                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br>                                                                                                       |                                                                                                                                                                                                                                                                                             | 22. Name and Address of Facility<br><b>March F/H West</b><br><b>4300 Wabash Avenue Baltimore, Md 21215</b>                                              |                                                                                                     |                                                                                                                                                                                              |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Lung Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                         |                                                                                                     |                                                                                                                                                                                              |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                         |                                                                                                     |                                                                                                                                                                                              |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                         |                                                                                                     |                                                                                                                                                                                              |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                         |                                                                                                     |                                                                                                                                                                                              |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                         |                                                                                                     |                                                                                                                                                                                              |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                                                                                                         |                                                                                                     |                                                                                                                                                                                              |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                       | 28a. Date of Injury (Month, Day Year)<br><b>M</b>                                                                                                                                                                                                                                           |                                                                                                                                                         | 28b. Time of Injury<br><b>1</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                              |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                       | 28d. Describe how injury occurred                                                                                                                                                                                                                                                           |                                                                                                                                                         |                                                                                                     |                                                                                                                                                                                              |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                |                                                                                                                                                         |                                                                                                     |                                                                                                                                                                                              |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                                              |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                         |                                                                                                     |                                                                                                                                                                                              |
| 29b. Signature and title of certifier<br><br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                       | 29c. License number<br><b>RES 000</b>                                                                                                                                                                                                                                                       |                                                                                                                                                         | 29d. Date signed (Month, Day, Year)<br><b>July 12, 2000</b>                                         |                                                                                                                                                                                              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Sinai Hospital 2401 W. Belvedere Ave Balto, Md 21215</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                                                                                                         |                                                                                                     |                                                                                                                                                                                              |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                       | 32. Registrar's Signature<br>                                                                                                                                                                           |                                                                                                                                                         |                                                                                                     |                                                                                                                                                                                              |

ORIGINAL



**Physician /Medical Examiner**  
1. Decedent's Name (First, Middle, Last)  
2. Date of Death  
3. Time of Death  
4a. Facility Name (If not institution, give street and number)  
4b. City, Town, or Location of Death  
5. Social Security Number  
6. Sex  
7. Age (In yrs. last birthday)  
8. Date of Birth (Month, Day, Year)  
9. Birthplace (State or Foreign Country)  
10a. State  
10b. County  
10c. City, Town or Location  
10d. Inside City Limits  
10e. Street and Number  
10f. Zip Code  
10g. Citizen of What Country?  
11. Marital Status  
12. Was Decedent Ever in U.S. Armed Forces?  
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
14. Race - American Indian, Black, White, etc.  
15. Decedent's Education (Specify only highest grade completed)  
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  
16b. Kind of Business/Industry  
17. Father's Name (First, Middle, Last)  
18. Mother's Name (First, Middle, Maiden Surname)  
19a. Informant's Name/Relationship (Type, Print)  
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  
20a. Method of Disposition  
20b. Place of Disposition (Name of cemetery, crematory or other place)  
20c. Location - City or Town, State  
21. Signature of Funeral Service Licensee  
22. Name and Address of Facility  
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  
23b. Did tobacco use contribute to the cause of death?  
24a. Was an autopsy performed?  
24b. Were autopsy findings available prior to completion of cause of death?  
25. Was case referred to medical examiner?  
26. Place of Death (Check only one)  
27. Manner of Death  
28a. Date of Injury (Month, Day, Year)  
28b. Time of Injury  
28c. Injury at Work?  
28d. Describe how injury occurred  
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  
28f. Location (Street and Number or Rural Route Number, City or Town, State)  
29a. Certifier (Check only one)  
29b. Signature and title of certifier  
29c. License number  
29d. Date signed (Month, Day, Year)  
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  
31. Date filed (Month, Day, Year)  
32. Registrar's Signature

**Funeral Director**  
Chapel Hill Nursing Center  
Randallstown  
Baltimore  
483-09-4875  
1 M 2 F  
87  
January 17, 1913  
South Dakota  
MD  
Baltimore  
Randallstown  
4003 Rouen Road  
21133  
U.S.A.  
1 Never Married 2 Married 3 Widowed 4 Divorced  
1 Yes 2 No  
1 Yes 2 No  
Specify: White  
Elementary/Secondary (0-12) College (1-4or 5+)  
12  
Salesperson  
Retail Sales  
Iver A. Heier  
Amanda Horvey  
Geraldine Coski (Daughter)  
112 Stillmeadow Drive, Joppa, Maryland 21085  
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  
Most Holy Redeemer Cemetery  
Baltimore, Maryland  
Loring Byers Funeral Directors, Inc.  
8728 Liberty Road, Randallstown, MD 21133

**Physician /Medical Examiner**  
Gangreen Lower Extremity  
Peripheral Vascular Disease  
Dementia  
Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  
Signature and title of certifier  
License number  
Date signed (Month, Day, Year)  
Name and address of person who completed cause of death (Item 23a) (Type, Print)  
Date filed (Month, Day, Year)  
Registrar's Signature

**Division of Vital Records, P.O. Box 68760,**  
Baltimore, Maryland 21215-0020

**State Registrar**





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State of Maryland / Department of Health and Mental Hygiene

AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO Certificate of Death

Reg. No.

00 22489

|                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                               |                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                          |                                                            |                                                                                                                                                                                                  |                                |                                                                                                                                                               |                                                 |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                            | 1. Decedent's Name (First, Middle, Last)<br><b>Stanley Jerome White, Jr.</b>                                  |                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                          | 2. Date of Death<br>Month Day Year<br><b>July 09, 2000</b> |                                                                                                                                                                                                  |                                |                                                                                                                                                               | 3. Time of Death<br><b>315 am</b>               |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 4a. Facility Name (If not institution, give street and number)<br><b>Johns Hopkins Bayview Medical Center</b> |                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                                                                                                                          | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |                                                                                                                                                                                                  |                                |                                                                                                                                                               | 4c. County of Death<br><b>N/A</b>               |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                          | 5. Social Security Number<br><b>216-17-5103</b>                                                               |                                                                                                                                                                                                                                                                             | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                                                                                                                          | 7. Age (In yrs. last birthday)<br><b>18</b> Yrs.           |                                                                                                                                                                                                  | If Under 1 Year<br>Months Days |                                                                                                                                                               | If Under 24 Hrs.<br>Hours Min.                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                              | 8. Date of Birth (Month, Day, Year)<br><b>01-25-82</b>                                                        |                                                                                                                                                                                                                                                                             | 9. Birthplace (State or Foreign Country)<br><b>MD</b>                      |                                                                                                                                                                                                                                                                                          | 10a. State<br><b>MD</b>                                    |                                                                                                                                                                                                  | 10b. County<br><b>NA</b>       |                                                                                                                                                               | 10c. City, Town or Location<br><b>Baltimore</b> |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                               | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                              |                                                                            | 10e. Street and Number<br><b>2706 Beryl Avenue</b>                                                                                                                                                                                                                                       |                                                            | 10f. Zip Code<br><b>21205</b>                                                                                                                                                                    |                                | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                   |                                                 |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                               |                                                                                                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:                                                                                             |                                                            | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                                                                                                                       |                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>10th Grade</b>                                           |                                                 |  |
| 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Unemployed</b>                                                                                                                                                                                                                                                                                               |                                                                                                               | 16b. Kind of Business/Industry<br><b>Unemployed</b>                                                                                                                                                                                                                         |                                                                            | 17. Father's Name (First, Middle, Last)<br><b>Stanley White, Sr.</b>                                                                                                                                                                                                                     |                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Phyllis Gillis</b>                                                                                                                       |                                | 19a. Informant's Name/Relationship (Type, Print)<br><b>Phyllis Gillis</b>                                                                                     |                                                 |  |
| 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2706 Beryl Avenue Baltimore, Maryland 21205</b>                                                                                                                                                                                                                                                                          |                                                                                                               | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                       |                                                                            | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD. Nat'l Mem. Pk. Cem. 07-15-2000 Laurel, MD</b>                                                                                                                                                           |                                                            | 20c. Location - City or Town, State                                                                                                                                                              |                                | 21. Signature of Funeral Service Licensee<br><b>Gabriele Cook</b>                                                                                             |                                                 |  |
| 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>                                                                                                                                                                                                                                                                                                                      |                                                                                                               | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>BLUNT FORCE INJURIES OF HEAD AND COMPRESSIONAL ASPHYXIA</b> |                                                                            | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                             |                                                            | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                         |                                                 |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                                                                                           |                                                                                                               | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                           |                                                                            | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                            | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide                          |                                | 28a. Date of Injury (Month, Day, Year)<br><b>Found: 7-9-00</b>                                                                                                |                                                 |  |
| 28b. Time of Injury<br><b>Found: A M</b>                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                               | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                 |                                                                            | 28d. Describe how injury occurred<br><b>SUBJECT SUSTAINED BLUNT FORCE INJURIES AND WAS ASPHYXIATED</b>                                                                                                                                                                                   |                                                            | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>TEAMSTERS HALL</b>                                                                                  |                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>6000 ERDMAN AVE. BALTIMORE, MD</b>                                         |                                                 |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                                                                                               | 29b. Signature and title of certifier<br><b>[Signature]</b>                                                                                                                                                                                                                 |                                                                            | 29c. License number<br><b>O.C.M.E.</b>                                                                                                                                                                                                                                                   |                                                            | 29d. Date signed (Month, Day, Year)<br><b>July 10, 2000</b>                                                                                                                                      |                                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARY G. RIPLEY M.D. 111 Penn Street, Baltimore, Maryland 21201</b> |                                                 |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 15 2000</b>                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                               | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                             |                                                                            | 33. Registrar's Title<br><b>[Signature]</b>                                                                                                                                                                                                                                              |                                                            | 34. Registrar's Name<br><b>[Signature]</b>                                                                                                                                                       |                                | 35. Registrar's Address<br><b>[Signature]</b>                                                                                                                 |                                                 |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene 00 22490

Certificate of Death

Reg. No.

|                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |                                              |
|----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Donald Earl Zealor                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                 |  | 2. Date of Death<br>Month Day Year<br>July 12 2000                                                                                                                                               |  |                                                                                      |                                                                  | 3. Time of Death<br>11:10PM                                                                                                                                                                              |  |                                              |
|                                                                      | 4a. Facility Name (If not institution, give street and number)<br>Gilchrist                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                 |  | 4b. City, Town, or Location of Death<br>Towson                                                                                                                                                   |  |                                                                                      |                                                                  | 4c. County of Death<br>Baltimore                                                                                                                                                                         |  |                                              |
| Funeral<br>Director                                                  | 5. Social Security Number<br>216-24-8193                                                                                                                                                                                                                                                                                                                                                                                      |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                                                                                                                                                                                                                  |  | 7. Age (In yrs. last birthday)<br>Yrs. 71                                                                                                                                                        |  | 8. Date of Birth (Month, Day, Year)<br>July 12 1929                                  |                                                                  | 9. Birthplace (State or Foreign Country)<br>Maryland                                                                                                                                                     |  |                                              |
|                                                                      | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                   |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |                                              |
| To Be Completed by Funeral Director                                  | 10a. State<br>Md.                                                                                                                                                                                                                                                                                                                                                                                                             |  | 10b. County<br>Baltimore                                                                                                                                                                                                                                                                                        |  | 10c. City, Town or Location<br>Baltimore                                                                                                                                                         |  |                                                                                      |                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                       |  |                                              |
|                                                                      | 10e. Street and Number<br>3108 Garden Ave.                                                                                                                                                                                                                                                                                                                                                                                    |  |                                                                                                                                                                                                                                                                                                                 |  | 10f. Zip Code<br>21234                                                                                                                                                                           |  | 10g. Citizen of What Country?<br>USA                                                 |                                                                  |                                                                                                                                                                                                          |  |                                              |
|                                                                      | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                        |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: Korean                                                                                                                                                    |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |                                                                                      | 14. Race - American Indian, Black, White, etc.<br>Specify: White |                                                                                                                                                                                                          |  |                                              |
|                                                                      | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                 |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Carpenter                                                                           |  |                                                                                      | 16b. Kind of Business/Industry<br>Construction                   |                                                                                                                                                                                                          |  |                                              |
|                                                                      | 17. Father's Name (First, Middle, Last)<br>James Zealor                                                                                                                                                                                                                                                                                                                                                                       |  |                                                                                                                                                                                                                                                                                                                 |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Florence Burton                                                                                                                             |  |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |                                              |
| To Be Completed by Funeral Director                                  | 19a. Informant's Name/Relationship (Type, Print)<br>Mrs. Bertha Zealor/ Wife                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                 |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3108 Garden Ave. Baltimore, Md. 21234                                                           |  |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |                                              |
|                                                                      | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                               |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Moreland Mem Park                                                                                                                                                                                                                     |  | 20c. Date<br>7-15-00                                                                                                                                                                             |  | 20d. Location - City or Town, State<br>Parkville, Md.                                |                                                                  |                                                                                                                                                                                                          |  |                                              |
|                                                                      | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                                                                                                                                 |  | 22. Name and Address of Facility<br>Ruck Towson Funeral Home, Inc.<br>1050 York Rd. Towson, Md. 21204                                                                                            |  |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |                                              |
|                                                                      | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                                                                                                                                                                                                      |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                                                                                                                          |  | Approximate Interval Between Onset and Death |
|                                                                      | Immediate Cause (Final disease or condition resulting in death)<br>a. Acute M. Myelogenous Leukemia<br>Due to (or as a consequence of):<br>b. NIDDM<br>Due to (or as a consequence of):<br>c. COPD<br>Due to (or as a consequence of):<br>d. Renal Insufficiency                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                                                                                                                          |  | 1 1/2 yrs.<br>yrs<br>yrs<br>yrs              |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |                                              |
|                                                                      | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                 |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                      |  |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |                                              |
|                                                                      | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input checked="" type="checkbox"/> Other (Specify) Hospice |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |                                              |
|                                                                      | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |  | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                           |  | 28b. Time of Injury<br>M                                                                                                                                                                         |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                                  | 28d. Describe how injury occurred                                                                                                                                                                        |  |                                              |
|                                                                      | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                        |  |                                                                                                                                                                                                                                                                                                                 |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                     |  |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |                                              |
| State Registrar                                                      | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |                                              |
|                                                                      | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                                                                                                                                                                                                                                                                                 |  | 29c. License number<br>D43172                                                                                                                                                                    |  | 29d. Date signed (Month, Day, Year)<br>July 17, 2000                                 |                                                                  |                                                                                                                                                                                                          |  |                                              |
|                                                                      | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Lisa Satterfield 9512 Harford Rd Baltimore MD 21234.                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |                                              |
| 31. Date filed (Month, Day, Year)<br>JUL 15 2000                     |                                                                                                                                                                                                                                                                                                                                                                                                                               |  |                                                                                                                                                                                                                                                                                                                 |  |                                                                                                                                                                                                  |  |                                                                                      |                                                                  |                                                                                                                                                                                                          |  |                                              |

ORIGINAL



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22491

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|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|-------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                         | 1. Decedent's Name (First, Middle, Last)<br><b>MARY RENSHAW ADAMS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                   |                                        | 2. Date of Death<br>Month Day Year<br><b>July 3 2000</b>                                                                                                                                     |                                                                                             |                                                             |                                                                         | 3. Time of Death<br><b>06:45PM</b>                                                             |                                                                                                                                                    |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 4a. Facility Name (If not Institution, give street and number)<br><b>4680 Pickeral Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                   |                                        | 4b. City, Town, or Location of Death<br><b>White Plains</b>                                                                                                                                  |                                                                                             |                                                             |                                                                         | 4c. County of Death<br><b>Charles</b>                                                          |                                                                                                                                                    |                                                                                                                                                                                                  |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                       | 5. Social Security Number<br><b>213-09-6773</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                        | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                        |                                        | 7. Age (In yrs. last birthday)<br><b>85</b>                                                                                                                                                  |                                                                                             | 8. Date of Birth (Month, Day, Year)<br><b>June 18, 1915</b> |                                                                         | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>                                    |                                                                                                                                                    |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                   |                                        |                                                                                                                                                                                              |                                                                                             |                                                             |                                                                         |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                       | 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                        | 10b. County<br><b>Charles</b>                                                                                                                     |                                        | 10c. City, Town or Location<br><b>White Plains</b>                                                                                                                                           |                                                                                             |                                                             |                                                                         | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                    |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 10e. Street and Number<br><b>4680 Pickeral Street</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                   |                                        | 10f. Zip Code<br><b>20695</b>                                                                                                                                                                |                                                                                             | 10g. Citizen of What Country?<br><b>USA</b>                 |                                                                         |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                        | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                        | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                                             |                                                             | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Proof Reader</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                   |                                        | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Banking</b>                                                                  |                                                                                             |                                                             |                                                                         | 16b. Kind of Business/Industry<br><b>Banking</b>                                               |                                                                                                                                                    |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 17. Father's Name (First, Middle, Last)<br><b>Levin Hiram Fisher</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                   |                                        | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Betty Alice Thomas Fisher</b>                                                                                                        |                                                                                             |                                                             |                                                                         |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |  |
| To Be Completed by Physician/Medical Examiner                                                                                                                                                                                                                                                                                                                                                                             | 19a. Informant's Name/Relationship (Type, Print)<br><b>Myrtle Skinner/Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                   |                                        | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 613 White Plains, MD 20695</b>                                                  |                                                                                             |                                                             |                                                                         |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                        | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Nanjemoy Baptist</b>                                                 |                                        | 20c. Date<br><b>7/7/00</b>                                                                                                                                                                   |                                                                                             | 20d. Location - City or Town, State<br><b>Nanjemoy</b>      |                                                                         |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                        | 22. Name and Address of Facility<br><b>AREHART-ECHOLS FUNERAL HOME</b><br><b>P.O. BOX 567 LA PLATA, MD. 20646</b>                                 |                                        |                                                                                                                                                                                              |                                                                                             |                                                             |                                                                         |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Stomach Cancer (Gastric Carcinoma) months</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                   |                                        |                                                                                                                                                                                              |                                                                                             |                                                             |                                                                         |                                                                                                |                                                                                                                                                    | Approximate Interval Between Onset and Death                                                                                                                                                     |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                   |                                        |                                                                                                                                                                                              |                                                                                             |                                                             |                                                                         |                                                                                                |                                                                                                                                                    | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                   |                                        |                                                                                                                                                                                              |                                                                                             |                                                             |                                                                         |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                                                                                  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 26. Place of Death (Check only one) <b>at home of daughter</b><br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) |                                                                                                                                                   |                                        |                                                                                                                                                                                              |                                                                                             |                                                             |                                                                         |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                 |                                                                                                                                                   | 28b. Time of Injury<br><b>M</b>        |                                                                                                                                                                                              | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                             | 28d. Describe how injury occurred                                       |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 29b. Signature and title of certifier<br>                                                                                                                                                                                           |                                                                                                                                                   | 29c. License number<br><b>D0033426</b> |                                                                                                                                                                                              | 29d. Date signed (Month, Day, Year)<br><b>July 5, 2000</b>                                  |                                                             |                                                                         |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>B. Larry Jenkins, Jr., P.O. Box 1724, La Plata, MD 20646</b>                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                   |                                        |                                                                                                                                                                                              |                                                                                             |                                                             |                                                                         |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |  |
| State Registrar                                                                                                                                                                                                                                                                                                                                                                                                           | 31. Date filed (Month, Day, Year)<br><b>JUL 06 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                   |                                        | 32. Registrar's Signature<br>                                                                            |                                                                                             |                                                             |                                                                         |                                                                                                |                                                                                                                                                    |                                                                                                                                                                                                  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22492

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Angela Rose Allen</b>                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 2. Date of Death<br>Month <b>Dec</b> Day <b>27</b> Year <b>2000</b>                                                                                                                          |  | 3. Time of Death<br><b>4:12 pm</b>                                                                                                                                                               |  |
| 4a. Facility Name (Not institution, give street and number)<br><b>Carroll Lutheran Village Health Care Ctr.</b>                                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 4b. City, Town, or Location of Death<br><b>Westminster</b>                                                                                                                                   |  | 4c. County of Death<br><b>Carroll</b>                                                                                                                                                            |  |
| 5. Social Security Number<br><b>215-18-9146</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                                                                                                                                                                                                                                                                                                                                                   |  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.                                                                                                                                             |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb 19 1917</b>                                                                                                                                        |  |
| 9. Birthplace (State or Foreign Country)<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
| 10a. State<br><b>MD</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 10b. County<br><b>Carroll</b>                                                                                                                                                                                                                                                                                                                                                                                                |  | 10c. City, Town or Location<br><b>Westminster</b>                                                                                                                                            |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                   |  |
| 10e. Street and Number<br><b>45 Washington Road</b>                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 10f. Zip Code<br><b>21157</b>                                                                                                                                                                |  | 10g. Citizen of What Country?<br><b>USA</b>                                                                                                                                                      |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                 |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                                                                                                                                            |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b><br><b>4</b>                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Pharmacist</b>                                                               |  | 16b. Kind of Business/Industry<br><b>St. Agnes Hospital</b>                                                                                                                                      |  |
| 17. Father's Name (First, Middle, Last)<br><b>Patrick Hackett</b>                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances Michaels</b>                                                                                                                 |  |                                                                                                                                                                                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Frances Nickolas/Daughter</b>                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>230 N. Gorsuch Rd Westminster, MD 21157</b>                                              |  |                                                                                                                                                                                                  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                          |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crest Lawn Cem</b>                                                                                                                                                                                                                                                                                                                              |  | Date<br><b>7/1</b>                                                                                                                                                                           |  | 20c. Location - City or Town, State<br><b>Ellicott City, MD</b>                                                                                                                                  |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 22. Name and Address of Facility<br><b>Pritts Funeral Home and Chapel</b><br><b>412 Washington Rd Westminster, MD 21157</b>                                                                  |  |                                                                                                                                                                                                  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. CHF</b><br><br>Due to (or as a consequence of):<br><b>b. Osteoporosis</b><br><br>Due to (or as a consequence of):<br><b>c. Emphysema - COPD</b><br><br>Due to (or as a consequence of):<br><b>d.</b> |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                              |  | Approximate Interval Between Onset and Death                                                                                                                                                     |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                         |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                              |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                              |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                               |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                              |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                                                                                                                  |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                        |  | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                                                                                                                                                       |  | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                                                                                         |  | 28d. Describe how injury occurred                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                                                                                                                                                                                                                                                                                                                                                                                   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
| 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                   |  | 29c. License number<br><b>D04278</b>                                                                                                                                                                                                                                                                                                                                                                                         |  | 29d. Date signed (Month, Day, Year)<br><b>June 28, 2000</b>                                                                                                                                  |  |                                                                                                                                                                                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Danni H. Griffin MD 19 Ridge Rd Westminster MD 21157</b>                                                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUN 28 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                                                            |  |                                                                                                                                                                                              |  |                                                                                                                                                                                                  |  |

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene 00 22493

## Certificate of Death

Reg. No.

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |                                                      |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                         | 1. Decedent's Name (First, Middle, Last)<br>Barbara Benjamin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                | 2. Date of Death<br>Month Day Year<br>June 30, 2000                                                                                                                                              |                                                                                                    | 3. Time of Death<br>1030 am                                                                                                                                                                              |                                                      |
|                                                                           | 4a. Facility Name (If not institution, give street and number)<br>Shock Trauma                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                | 4b. City, Town, or Location of Death<br>Baltimore                                                                                                                                                |                                                                                                    | 4c. County of Death<br>N/A                                                                                                                                                                               |                                                      |
| Funeral<br>Director                                                       | 5. Social Security Number<br>220-50-4717                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                    | 7. Age (In yrs. last birthday)<br>53 Yrs.                                                                                                                                                                                                                                                               | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                   | 8. Date of Birth (Month, Day, Year)<br>June 17 1947                                                |                                                                                                                                                                                                          | 9. Birthplace (State or Foreign Country)<br>Maryland |
|                                                                           | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |                                                      |
| To Be Completed by Funeral Director                                       | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 10b. County<br>Carroll                                                                                            | 10c. City, Town or Location<br>Westminster                                                                                                                                                                                                                                                              |                                |                                                                                                                                                                                                  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                                                                                                                          |                                                      |
|                                                                           | 10e. Street and Number<br>1510 Chris Lane                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                   | 10f. Zip Code<br>21158                                                                                                                                                                                                                                                                                  |                                | 10g. Citizen of What Country?<br>USA                                                                                                                                                             |                                                                                                    |                                                                                                                                                                                                          |                                                      |
|                                                                           | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                                                                                                                         |                                                      |
|                                                                           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (14 or 5+) 2                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Secretary                                                                                                                                                                                  |                                | 16b. Kind of Business/Industry<br>Carroll County Public Schools                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |                                                      |
|                                                                           | 17. Father's Name (First, Middle, Last)<br>Charles Eugene Ervin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary Louise Row                                                                                                                             |                                                                                                    |                                                                                                                                                                                                          |                                                      |
| To Be Completed by Physician/Medical Examiner                             | 19a. Informant's Name/Relationship (Type, Print)<br>John R. Benjamin Husband                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1510 Chris Lane Westminster, MD 21158                                                           |                                                                                                    |                                                                                                                                                                                                          |                                                      |
|                                                                           | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Carroll Cremation Inc 7-2                                                                                                                                                                                                     |                                | 20c. Location - City or Town, State<br>Hampstead, Maryland                                                                                                                                       |                                                                                                    |                                                                                                                                                                                                          |                                                      |
|                                                                           | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                   | 22. Name and Address of Facility<br>Pritts Funeral Home and Chapel, P.A.<br>412 Washington Rd. Westminster, MD 21157                                                                                                                                                                                    |                                |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |                                                      |
|                                                                           | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Head Injury<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |                                                      |
|                                                                           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                                  |                                                                                                    | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                      |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                  |                                |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |                                                      |
|                                                                           | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |                                                      |
|                                                                           | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                                                                                                                                                                                                                    |                                                                                                                   | 28a. Date of Injury (Month, Day, Year)<br>06/29/00                                                                                                                                                                                                                                                      |                                | 28b. Time of Injury<br>1852P                                                                                                                                                                     |                                                                                                    | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                          |                                                      |
|                                                                           | 28d. Describe how injury occurred<br>Fell off bicycle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br>Pleasant Valley Rd at Huges Shop Rd.                                                                                                                                                                                    |                                |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |                                                      |
|                                                                           | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                                                                                                                                          |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |                                                      |
| State Registrar                                                           | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                | 29c. License number<br>O.C.M.E.                                                                                                                                                                  |                                                                                                    | 29d. Date signed (Month, Day, Year)<br>July 02, 2000                                                                                                                                                     |                                                      |
|                                                                           | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>David Fowler, M.D. 111 Penn Street, Baltimore, Maryland 21201                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                   |                                                                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |                                                      |
| 31. Date filed (Month, Day, Year)<br>JUL 03 2000                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 32. Registrar's Signature<br> |                                                                                                                                                                                                                                                                                                         |                                |                                                                                                                                                                                                  |                                                                                                    |                                                                                                                                                                                                          |                                                      |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22494

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NELLIE KATHLEEN BRADSHAW

2. Date of Death

Month Day Year  
July 2, 2000

3. Time of Death

0213

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death

SALISBURY

4c. County of Death

WICOMICO

5. Social Security Number

218-48-5140

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
December 8, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Rhodes Point

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3277 Marsh Road

10f. Zip Code

21824

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10College (1-4 or 5+)  
-16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Roland Hoffman

18. Mother's Name (First, Middle, Maiden Surname)

V. Lynette Tyler

19a. Informant's Name/Relationship (Type, Print)

Maxine Landon (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3159 Marsh Road - Rhodes Point, MD 21824

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Calvary Church Cemetery

Date

7/6/00

20c. Location - City or Town, State

Rhodes Point, MD

21. Signature of Funeral Service Licenses

Robert H. Bradshaw, Jr.

22. Name and Address of Facility

Bradshaw & Sons Funeral Home  
306 W. Main St.- Crisfield, MD 2181723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Arteriosclerotic Cardiovascular Disease 2 yrs*

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Insulin Dependent Diabetes Mellitus*  
*Essential Hypertension*  
*Carotid Stenosis, Dementia*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident  
3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gregorio M. Belloso, MD

29c. License number

D 29505

29d. Date signed (Month, Day, Year)

7-3-2000

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GREGORIO M. BELLOSO, MD; 5302 CHINABERRY DR., SALISBURY, MD 21801

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 07 2000

32. Registrar's Signature

Benita B. Sparks

ORIGINAL

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Nellie Bradshaw SS# 218-48-5140



100

with the results

1007-1011

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22495

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Reba Ellen Butler

2. Date of Death

Month Day Year  
July 5, 2000

3. Time of Death

3:35 AM

4a. Facility Name (If not institution, give street and number)

33338 West Office Road

4b. City, Town, or Location of Death

Princess Anne

4c. County of Death

Somerset

Funeral  
Director

5. Social Security Number

215-26-4476

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
08/21/1931

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Princess Anne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

33338 West Post Office Road

10f. Zip Code

21853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Dispatcher

16b. Kind of Business/Industry

Oil Company

17. Father's Name (First, Middle, Last)

Elton Dykes

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Dryden

19a. Informant's Name/Relationship (Type, Print)

Diane Ballard/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

33338 West Post Office Road, Princess Anne, Md. 21853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Perryhawkin Christian Cem. 7/8/00 Princess Anne, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

James L. Hurnan M00295

22. Name and Address of Facility

Hinman Funeral Home  
11673 Somerset Ave., Princess Anne, Md. 2185323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Lung Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

one yr

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

David Corral, MD

29c. License number

D26278

29d. Date signed (Month, Day, Year)

7-5-00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David Corral, MD 145E. Carroll St. Solis, MD 21801

31. Data filed (Month, Day, Year)

JUL 05 2000

32. Registrar's Signature

Beverly B. Sparks

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22496

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                       |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                   |                                                                                      |                                                      |                                   |                                                                                                    |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------------------------------|-----------------------------------|----------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                             | 1. Decedent's Name (First, Middle, Last)<br>Marguerite Cole                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                       |                                                                                                                                                       |                                                                              | 2. Date of Death<br>Month: June, Day: 30, Year: 2000                                                                                                                                              |                                                                                      |                                                      |                                   | 3. Time of Death<br>8:10 AM                                                                        |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 4a. Facility Name (If not institution, give street and number)<br>Chesapeake Hospice House                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                       |                                                                                                                                                       |                                                                              | 4b. City, Town, or Location of Death<br>Linthicum                                                                                                                                                 |                                                                                      |                                                      |                                   | 4c. County of Death<br>Anne Arundel                                                                |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                           | 5. Social Security Number<br>022-26-2938                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                       | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                                                        |                                                                              | 7. Age (In yrs. last birthday)<br>Yrs. 78                                                                                                                                                         |                                                                                      | 8. Date of Birth (Month, Day, Year)<br>April 7, 1922 |                                   | 9. Birthplace (State or Foreign Country)<br>Maryland                                               |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                       |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                   |                                                                                      |                                                      |                                   |                                                                                                    |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
| To Be Completed by Funeral Director                                                                                                                                                                                                                                                                                                                                                                                           | 10a. State<br>Maryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                       | 10b. County<br>Anne Arundel                                                                                                                           |                                                                              | 10c. City, Town or Location<br>Crofton                                                                                                                                                            |                                                                                      |                                                      |                                   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 10e. Street and Number<br>1703 Tarrytown Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                       |                                                                                                                                                       |                                                                              | 10f. Zip Code<br>21114                                                                                                                                                                            |                                                                                      | 10g. Citizen of What Country?<br>USA                 |                                   |                                                                                                    |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                   |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                                                              | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                                                                      |                                                      |                                   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                       |                                                                                                                                                       |                                                                              | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker                                                                            |                                                                                      |                                                      |                                   | 16b. Kind of Business/Industry<br>Own Home                                                         |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. Father's Name (First, Middle, Last)<br>John C. Robertson                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                       |                                                                                                                                                       |                                                                              | 18. Mother's Name (First, Middle, Maiden Surname)<br>Edith H. Reed                                                                                                                                |                                                                                      |                                                      |                                   |                                                                                                    |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 19a. Informant's Name/Relationship (Type, Print)<br>Lanier G. Cole/ Husband                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                       |                                                                                                                                                       |                                                                              | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1703 Tarrytown Avenue Crofton, Maryland 21114                                                    |                                                                                      |                                                      |                                   |                                                                                                    |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                          |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Lakemont Memorial Gardens                                                   |                                                                              | 20c. Location - City or Town, State<br>07-03-00 Davidsonville, Maryland                                                                                                                           |                                                                                      |                                                      |                                   |                                                                                                    |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                       |                                                                                                                                                       |                                                                              | 22. Name and Address of Facility<br>John M. Taylor Funeral Home, Inc.<br>147 Duke of Gloucester Street Annapolis, Md. 21401                                                                       |                                                                                      |                                                      |                                   |                                                                                                    |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <u>Malignant Melanoma</u><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |                                       |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                   |                                                                                      |                                                      |                                   |                                                                                                    |                                                                                                                                                                                                                                                                                                                 | Approximate Interval Between Onset and Death<br>12 months                                                                                                                                                |                                                                                                                                                        |  |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                       |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                   |                                                                                      |                                                      |                                   |                                                                                                    |                                                                                                                                                                                                                                                                                                                 | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                                                                                                                                        |  |                                                |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                       |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                   |                                                                                      |                                                      |                                   |                                                                                                    | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                       |                                                                                                                                                                                                          | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |                                                |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                       |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                   |                                                                                      |                                                      |                                   |                                                                                                    | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Hospice |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 28a. Date of Injury (Month, Day Year) |                                                                                                                                                       | 28b. Time of Injury<br>M                                                     |                                                                                                                                                                                                   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |                                                      | 28d. Describe how injury occurred |                                                                                                    |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                       |                                                                                                                                                       | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |                                                                                                                                                                                                   |                                                                                      |                                                      |                                   |                                                                                                    |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                       |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                   |                                                                                      |                                                      |                                   |                                                                                                    | 29b. Signature and title of certifier<br>                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                          | 29c. License number<br>731602                                                                                                                          |  | 29d. Date signed (Month, Day, Year)<br>6/30/00 |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>George Cavanagh MD 4201 Mitchellville Rd Bowie, MD 20716                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                       |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                   |                                                                                      |                                                      |                                   |                                                                                                    |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |
| 31. Date filed (Month, Day, Year)<br>JUL 03 2000                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 32. Registrar's Signature<br>         |                                                                                                                                                       |                                                                              |                                                                                                                                                                                                   |                                                                                      |                                                      |                                   |                                                                                                    |                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                          |                                                                                                                                                        |  |                                                |  |

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

00 22497

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 1. Decedent's Name (First, Middle, Last)<br><b>Jean W. Colbert</b>                                    |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month <b>June</b> Day <b>24</b> Year <b>2000</b> |                                                                                                                                                                                                  | 3. Time of Death<br><b>6:14 P.M.</b>                                                           |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 4a. Facility Name (If not institution, give street and number)<br><b>Fairhaven Health Care Center</b> |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br><b>Sykesville</b>            |                                                                                                                                                                                                  | 4c. County of Death<br><b>Carroll</b>                                                          |                                                                                                                                         |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 5. Social Security Number<br><b>213 03 3705</b>                                                       |                                                                                                                                                                                                                                                                                             | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (in yrs. last birthday)<br><b>90</b> Yrs.                                                                                                                                             | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.                                                                                                                                                                   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 23, 1909</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                                                             |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Usual Residence of Decedent                                                                           |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
| 10a. State<br><b>Md.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                       | 10b. County<br><b>Carroll</b>                                                                                                                                                                                                                                                               |                                                                            | 10c. City, Town or Location<br><b>Sykesville</b>                                                                                                                                             |                                                                      |                                                                                                                                                                                                  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |                                                                                                                                         |
| 10e. Street and Number<br><b>7200 Third Ave.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            | 10f. Zip Code<br><b>21784</b>                                                                                                                                                                |                                                                      | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                                                                                                                                   |                                                                                                |                                                                                                                                         |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                           |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                                      |                                                                                                                                                                                                  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |                                                                                                                                         |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>4</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                                                |                                                                      |                                                                                                                                                                                                  | 16b. Kind of Business/Industry<br><b>Domestic</b>                                              |                                                                                                                                         |
| 17. Father's Name (First, Middle, Last)<br><b>Wrightson Chambers</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Grimes</b>                                                                                                                     |                                                                      |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Addie D. Baldwin (Cousin)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1350 St. Stephens Church Rd. Crownsville, Md. 21032</b>                                  |                                                                      |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>                                                                                                                                                                                          |                                                                            | Date<br><b>6/27/00</b>                                                                                                                                                                       |                                                                      | 20c. Location - City or Town, State<br><b>Woodlawn, Md.</b>                                                                                                                                      |                                                                                                |                                                                                                                                         |
| 21. Signature of Funeral Service Licensee<br><b>Harry W. Haight</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            | 22. Name and Address of Facility<br><b>Haight Funeral Home &amp; Chapel<br/>P.O. Box 195 Sykesville, Md. 21784</b>                                                                           |                                                                      |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
| 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>c. carcinoma of the gallbladder</b><br>Due to (or as a consequence of):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d.</b> |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                                                                | Approximate Interval Between Onset and Death<br><b>3 months</b>                                                                         |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |                                                                                                |                                                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                            |                                                                                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                       | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                                                                                                                                                                                                                                                                                                                                                          |                                                                                                       | 28a. Date of Injury (Month, Day, Year)                                                                                                                                                                                                                                                      |                                                                            | 28b. Time of Injury<br><b>M</b>                                                                                                                                                              |                                                                      | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                                                                                                      |                                                                                                | 28d. Describe how Injury occurred                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                       | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                                                                                                                                                                                                      |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                                                                | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                                                            |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                                                                                                                                                                                                              |                                                                                                       | 29b. Signature and title of certifier<br><b>Chris O. Allen MD</b>                                                                                                                                                                                                                           |                                                                            | 29c. License number<br><b>D34406</b>                                                                                                                                                         |                                                                      | 29d. Date signed (Month, Day, Year)<br><b>June 26, 00</b>                                                                                                                                        |                                                                                                |                                                                                                                                         |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Richmond P. Allan, 1645 Liberty Rd. Eldersburg, MD 21784</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                       |                                                                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |
| 31. Date filed (Month, Day, Year)<br><b>JUN 27 2000</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                       | 32. Registrar's Signature<br><b>[Signature]</b>                                                                                                                                                                                                                                             |                                                                            |                                                                                                                                                                                              |                                                                      |                                                                                                                                                                                                  |                                                                                                |                                                                                                                                         |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





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State of Maryland / Department of Health and Mental Hygiene

00 22498

## Certificate of Death

Reg. No.

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                              |                                                     |                                                                                                 |                                                  |                                                                                                                                                                                                          |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| Physician<br>/Medical<br>Examiner                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1. Decedent's Name (First, Middle, Last)<br>Samuel Wilson Channell                           |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                              | 2. Date of Death<br>Month: June Day: 30 Year: 2000  |                                                                                                 | 3. Time of Death<br>3:15 am                      |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 4a. Facility Name (If not institution, give street and number)<br>Westminster Nursing Center |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                              | 4b. City, Town, or Location of Death<br>Westminster |                                                                                                 | 4c. County of Death<br>Carroll                   |                                                                                                                                                                                                          |  |
| Funeral<br>Director                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 5. Social Security Number<br><del>216-01-5483</del><br>216-04-5483                           |                                                                                                                                                                                                                                                                                                         | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |                                                                                                                                                                                              | 7. Age (In yrs. last birthday)<br>86 Yrs.           |                                                                                                 | 8. Date of Birth (Month, Day, Year)<br>8-24-1913 |                                                                                                                                                                                                          |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 9. Birthplace (State or Foreign Country)<br>Pennsylvania                                     |                                                                                                                                                                                                                                                                                                         | 10a. State<br>MD                                                           |                                                                                                                                                                                              | 10b. County<br>Carroll                              |                                                                                                 | 10c. City, Town or Location<br>Westminster       |                                                                                                                                                                                                          |  |
| Usual Residence of Decedent                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                                          |                                                                            | 10e. Street and Number<br>339 Stoner Ave                                                                                                                                                     |                                                     | 10f. Zip Code<br>21157                                                                          |                                                  | 10g. Citizen of What Country?<br>USA                                                                                                                                                                     |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                                                                                                                                                                                                                                                                                                                 |                                                                                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                                                                                                                                                       |                                                                            | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                                     | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                |                                                  |                                                                                                                                                                                                          |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Collega (1-4 or 5+) 0                                                                                                                                                                      |                                                                            | 16b. Kind of Business/Industry<br>Mechanic                                                                                                                                                   |                                                     | 16c. Kind of Business/Industry<br>Aero Oil                                                      |                                                  |                                                                                                                                                                                                          |  |
| 17. Father's Name (First, Middle, Last)<br>William Cleveland Channell                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                            | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lavada Boyd                                                                                                                             |                                                     |                                                                                                 |                                                  |                                                                                                                                                                                                          |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Elizabeth Roop Channell                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>339 Stoner Ave. Westminster, MD 21157                                                       |                                                     |                                                                                                 |                                                  |                                                                                                                                                                                                          |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                                                                                                                                                                                                                                           |                                                                                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fawn Grove Ch. Cem.                                                                                                                                                                                                           |                                                                            | Date<br>7-2                                                                                                                                                                                  |                                                     | 20c. Location - City or Town, State<br>Fawn Grove, PA                                           |                                                  |                                                                                                                                                                                                          |  |
| 21. Signature of Funeral Service Licensee<br>                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              | 22. Name and Address of Facility<br>Pritts Funeral Home and Chapel, P.A.<br>412 Washington Rd. Westminster, MD 21157                                                                                                                                                                                    |                                                                            |                                                                                                                                                                                              |                                                     |                                                                                                 |                                                  |                                                                                                                                                                                                          |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. End stage chronic obstructive lung disease 14 year<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of): |                                                                                              | Approximate Interval Between Onset and Death                                                                                                                                                                                                                                                            |                                                                            |                                                                                                                                                                                              |                                                     |                                                                                                 |                                                  |                                                                                                                                                                                                          |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                              |                                                     |                                                                                                 |                                                  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                  |                                                                            |                                                                                                                                                                                              |                                                     |                                                                                                 |                                                  |                                                                                                                                                                                                          |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                              | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                                                                            |                                                                                                                                                                                              |                                                     |                                                                                                 |                                                  |                                                                                                                                                                                                          |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide                                                                                                                                                                                                                      |                                                                                              | 28a. Date of Injury (Month, Day Year)                                                                                                                                                                                                                                                                   |                                                                            | 28b. Time of Injury<br>M                                                                                                                                                                     |                                                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |                                                  | 28d. Describe how injury occurred                                                                                                                                                                        |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                                                               |                                                                                              | 29b. Signature and title of certifier<br>INTERNIST                                                                                                                                                                                                                                                      |                                                                            | 29c. License number<br>D 52035                                                                                                                                                               |                                                     | 29d. Date signed (Month, Day, Year)<br>June 30, 2000                                            |                                                  |                                                                                                                                                                                                          |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>BINU CHACKO 295 Stoner Avenue, Westminster, MD 21157                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              |                                                                                                                                                                                                                                                                                                         |                                                                            |                                                                                                                                                                                              |                                                     |                                                                                                 |                                                  |                                                                                                                                                                                                          |  |
| 31. Date filed (Month, Day, Year)<br>JUN 30 2000                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              | 32. Registrar's Signature<br>                                                                                                                                                                                                                                                                           |                                                                            |                                                                                                                                                                                              |                                                     |                                                                                                 |                                                  |                                                                                                                                                                                                          |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 22499

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ADA

COX

2. Date of Death  
Month Day Year  
07 03 20003. Time of Death  
7:15 AM

4a. Facility Name (If not institution, give street and number)

Manokin Manor Nursing Home

4b. City, Town, or Location of Death

Princess Anne

4c. County of Death

Somerset

Funeral  
Director

5. Social Security Number

219-07-3868

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

3 12

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

03-22-1918

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland Somerset

10b. County

10c. City, Town or Location

Princess Anne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11974 Edgehill Terrace

10f. Zip Code

21853

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

-

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Grocery Store Owner

16b. Kind of Business/Industry

Food Service

17. Father's Name (First, Middle, Last)

James Horner

18. Mother's Name (First, Middle, Maiden Surname)

Almira Insley

19a. Informant's Name/Relationship (Type, Print)

Cynthia Elza/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 202, Princess Anne, Md. 21853

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Salisbury Crematory

Date

7/11/00

20c. Location - City or Town, State

Salisbury, Md.

21. Signature of Funeral Service Licensee

*James L. Him*

M00295

22. Name and Address of Facility

Hinman Funeral Home, P.A.

11673 Somerset Ave, Princess Anne, Md. 21853

23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

*Advanced Multi-Infarct Dementia 5 yrs*

Approximate Interval Between Onset and Death

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Parkinson's Disease**Essential Hypertension**Diabetes Mellitus Type II. Anemia*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Gregorio M. Bellosso, M.D.*

29c. License number

D29505

29d. Date signed (Month, Day, Year)

7-3-2000

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

GREGORIO M. BELLOSSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

31. Date filed (Month, Day, Year)

JUL 05 2000

32. Registrar's Signature

*Geneva G. Sparks*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #5, 6/23/2000, BMW, Montg. Co.

Amended #23b, 6/16/2000, Per MD, JW, Mont Co. Certificate of Death

Reg. No.

00 22500

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Palmer Chambers

2. Date of Death

Month 06 Day 09 Year 2000

3. Time of Death

5:20pm

4a. Facility Name (If not institution, give street and number)

Manor Care 6530 Democracy Blvd.

4b. City, Town, or Location of Death

Bethesda, MD

4c. County of Death

Montgomery Co.

Funeral  
Director

5. Social Security Number

020-00-2419

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

January 18, 1914

9. Birthplace (State or Foreign Country)

Guilford, Ct.

Usual Residence of Decedent

10a. State

Ct.

10b. County

New Haven

10c. City, Town or Location

Guilford

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

71 High Meadow Road

10f. Zip Code

06437

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Business Man

16b. Kind of Business/Industry

Self-Employed

17. Father's Name (First, Middle, Last)

Palmer Smith Chambers

18. Mother's Name (First, Middle, Maiden Surname)

Anna Parsons

19a. Informant's Name/Relationship (Type, Print)

Britta Chambers/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 123 Guilford Connecticut, 06437

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

June 11, 2000

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

DeVol Funeral Home  
2222 Wisconsin Ave., N.W. Wash. D.C. 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

Pneumonia

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

GASTROINTESTINAL BLEED

CEREBRAL VASCULAR ACCIDENT

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Medical Examiner

2 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D35791

29d. Date signed (Month, Day, Year)

6/9/00

30. Name and address of person who completed cause of death (Item 20e) (Type, Print)

MERLYN VENURY 9801 GEORGIA AVE, SILVER SPRING

31. Date filed (Month, Day, Year)

JUN 16 2000

32. Registrar's Signature

*[Signature]*

MD 20902

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



